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The Journal Inching South Carolina Medical Association

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The Inurnal

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VOLUME XLIV

January, 1948

Number 1

Fifty Years

THOMAS A. PITTS, M. D. Columbia, S. C.

(This paper was presented at a banquet honoring Dr. Arthur Wolfe Browning of Elloree, S. C., upon the completion of fifty years of general practice.

In addition to paying homage to Dr. Browning, Dr. Pitts has presented a striking picture of the changes which have taken place in the field of medicine during the past half century. Editor)

For more reasons than one, I consider it a distinct privilege to be asked to do honor to so eminent a man in the practicing field of medicine. To begin with, my revered father gave his life in the same field, and from him I learned some of the greatest lessons medical ethics has to teach; from him I learned that the general practitioner's life is one of constant service night and day, from hut to mansion, in all kinds of weather over all kinds of roads. I learned that the "love of humanity" and the preservation of life called for a sacrificing and a forgetting of self.

But of this man whom we honor. What of him? I would like to draw a picture for you—a background to show him off as a graduate of the Baltimore Medical College in 1897-at the age of twenty-one, one of the youngest men in the class and with grades placing him near the top. Perhaps it was, in part, his boyhood days on the farm near Elloree that made him thus resourceful. No doubt these early farm days made him a lover of horses and laid the ground work for his excellence in the tilting tournaments of which he is justly proud. This farm boy life, too, fostered his love for dogs and hunting, for throughout his life he has been a Nimrod of note and one of the best wing shots in this area. His ability to train animals, both horses and dogs, is likewise noteworthy and it is agreed too, that he has always had a "way with the fair sex", a grouping that is not uncommon. I will not peruse this thought further as some things are better unsaid.

I don't know what the Baltimore Medical College looked like in that day nor what were the thoughts in that young man's mind as he stepped on the brink of his medical practice, but I know something of the times and you might be interested and even amused

to remember some of the things and events of those days, if you too lived then, or to hear about them if you are of the younger fry.

He may have been decked in either a turtle-neck sweater or striped blazer and checkered trousers, if he were going bicycling, as this was the golden age of the wheel when it set the theme of the most popular song, "You'll look sweet upon the seat of a bicycle built for two". He probably included among his accessories, tight trousers, a high collar, sometimes rubber, and a derby hat. Lawn parties, box socials, and parlor games were good entertainment and the cake-walk was popular at dances as well as the waltz and the German. If he could, he went to the World's Columbian Exposition where he saw a burlesque and "Little Egypt" do the hoochee-coochee.

Perhaps you might like to reflect on an era that had sugar for 4c a pound, eggs 14c a dozen, a turkey dinner at 20c, supper or breakfast for 15c, and men's box calf shoes at \$2.50. The word "automobile" had yet to be coined. It was called the "horseless carriage" when treated seriously, and more frequently, the "devil-wagon", and the driver, "the engineer". Doctors had not heard of 606, or of insulin, and women doctors were looked on partly with ridicule. The general praetitioner had to depend chiefly upon himself to diagnose and determine treatment. And, if he were in doubt, he did something palliative, for God is good—19 out of 20 will get well anyway.

With these remarks, we now meet our hero in his next role—that of general practitioner in a small town, Ellorec. Population was still more rural than urban. The trend from farm to factory, from handicraft to mass production, from country to city, was beginning, which was to create new medical problems. His father's were of a different kind. The older gentleman had to saturate a rag with chloroform and put it in a teacup, holding it over the patient's nose while reducing a fracture or dislocation. Thermometers were yet to come into general use and a doctor had to get his bearings from a look at the tongue and by feeling

the pulse. Bandages were from old sheets and absorbent cotton was not sold widely. Bed pans had sponts on them and many could practice medicine all day if the calomel and quinine held out. But the doctor of the nineties and thereafter was confronted with kaleidoscopic changes. One fad after another would arise and be discredited. Do you remember the oxygenator and later, Abrahm's treatment? There were many other theories in vogue then that have long since been outmoded, even as the present ones will be in the future. To list some seems in order. Myasma was the poisonous vapor that drifted up from the swamps to cause fevers, and night air was certainly to be avoided. May-pops and yellow backed watermelons were the accepted cause of fevers. Inflammation of the bowel became typhalitis when Edward of England died of it; later it was called appendicitis from which surgeons of a later day grew rich and famous.

Membranous croup was one of the killers—no diptheria antitoxin was yet available. Locked bowels, continued fever, cholera infantum, milk fever and biliousness were real and sometimes hard to handle. Mothers chewed their food for their babies and more or less gracefully spat some of the premasticated food on their fingers and put it into the child's mouth. An asafoetida bag around the child's neck was used to prevent disease. Clothes were sewed on for the winter, and more student hours were spent on typhoid fever than any other one disease. The tonsil fad had not arrived.

Our young graduate met many strange things when he saddled his horse and threw across his back saddle bags that held most of the known armamentarium against disease. He knew a lot about botany and materia medica for these were the days when such was taught from books and in class and not, as is now the case, by drug salesman and detail men.

When Doctor Arthur Wolfe Browning came to Elloree in June 1897, he had seen six appendectomies in Baltimore while in college, but he soon found it necessary to assist at one performed on the dining table of the Bardin Hotel. He became expert in front porch operations, among them the amputation of a Negro's leg with the assistance of a farmer who gave the anaesthetic. This Negro still walks the streets of Elloree, doing all right with his homemade peg. Another was the case of the man who had been cut from chest bone to umbilicus, with intestines out through the wound. Doctor Browning washed them with saline and put them back and closed the wound. The patient's temperature never went over 100, and he came to the doctor's office about three months later to ask if he were going to live.

Doctor Browning has delivered more than four thousand babies, among them a two-headed child, a sixteen pound baby boy, three sets of triplets, several twins, all unassisted! Some of his most trying times were during the period before and during World War I. There were epidemics of typhoid, colitis, malaria and hemorrhagic fever. During the War he served as chairman and examiner of the local board at Ellorce. In the "flu" epidemic of 1918, he averaged over one hundred home calls a day for three months, not counting the patients that came to his office. He delivered over two hundred babies that year, all of this time still doing the local board work, and with weather so raw and cold that people had to bring their brass monkeys in every night.

He was President of the old Orangeburg County Medical Association, and drove horse and buggy to Orangeburg to attend the meetings, taking most of the day. Later he was President of the Edisto Medical Association. He has been on many State Medical Association Committees, and was selected to represent South Carolina at the first and second National Rural Health Conferences in Chicago, and the Southern Rural Health Conference in Chattanooga. He was on the Committee of Seventeen which worked so valiantly for the expansion of the Medical College at Charleston last year after their thorough and complete investigation.

It is men such as this who have made the phenomenal progress of medicine during the past fifty years possible. These benefits to mankind didn't just happen! These beloved practitioners of medicine of this time and before endeared themselves to the people by their devotion to duty and by strict adherence to the oath of Hippocrates, and placed our profession on a high plane, even above the calling of the cloth in the minds of a few. Now this position is being seriously undermined by selfish commercialism from within and by the socialistic propaganda from without which is sweeping the country. Physicians are disappearing from general practice. Students of the situation have predicted that the family doctor will disappear altogether from the American scene. I hope not. But the fact remains that there are fewer general practitioners today than there were fifty years ago. The country doctor, through his knowledge, ingenuity and courage has saved many lives. There are so many lessons for all of us to be learned at the feet of such pioneers in medicine. The high standards of our profession were built by them.

Under the stress and strain of modren life, the family physician, by which I mean the man with experience in general practice, is still the most valuable man of medicine to the individual, the family, the community and the nation. The investigators searching for clues to aid in the solution of the mystery of the vanishing physician, will find that the vogue for specialization has played the main role in the decline of the family doctor. There are American boards of this and that where entirely too much stress is placed on didactic training. Many such specialists are comparable to the aviator whose only training is

by correspondence and these 90-day wonders really charge.

There is a place and a need for the specialist but the general practitioner, due to his experience in treating all kinds of diseases, can never be replaced. For a practitioner gradually develops confidence as there is no one else to rely upon. It is he who should determine the need of a specialist, and in most instances, he is best fitted to select the specialist needed. The specialist tends to take more interest in the disease than in the patient who is the victim of the disease. A good family doctor never loses sight of the patient, but a specialist and his patient are usually strangers-he mistrusts him because he knows that a specialist, like a shoemaker, tends to stick to his last, his specialty. Most of you know this. At a certain medical school, specialists come regularly to lecture, and for material to illustrate the points they wish to make, they turn to the wards in the available hospital. Once a psychiatrist came to lecture, found in the wards a patient with a pronounced psychosis and used her as a text for his discourse. Later, a dermatologist found in the wards a sufferer from numerous skin lesions and used this patient to illustrate his points. Subsequently an expert on digestive disturbances selected a patient with persistent diarrhea, and since he had spent twenty years in China, the students made elaborate study of the stools to discover the eause. No one was struck by the coincidence that the patient who was used by each man, as an object lesson, was the same person, until a general practitioner, an old country doctor saw her and after a glance at her history said, "Why here you have something really remarkable, dementia, dermatitis, diarrhea. This woman has pellagra". This tendency to wear blinders, to see only his own field, is one of the specialists' handicaps. His achievements are the more remarkable because he struggles against so many of these handicaps, handicaps rooted in his own psychology, handieaps arising from his inevitable ignorance of his patients, handicaps arising from the fact that he knows his own field-or he doesn't! The increasing tendency towards specialization has led medicine to follow the example of industry-to establish a production line. The human chassis, on a belt conveyor, passes under the eyes of a regiment of specialists, and one does this, and another does that, each restricting himself to his particular field. and, like the mechanic who affixed the bumper and thought he built the ear, each doctor, when the patient recovers, may secretly assure himself that he, and he alone, accomplished the cure.

Entirely too many are entering the special fields. If this trend continues, who is going to do the work? It is my honest and sincere judgment that there is no grander, no more self-satisfying work than that of the general practitioner. Doctor Frank Lahey, in an address to the Connecticut State Medical Society said, "There is no substitution for long hours and hard work. I think it is a misfortune that there is a

tendency, it seems to me, to overlook the fact that long hours and hard work are the things that have built our characters and the characters of our parents".

It is the definite conviction of some of the outstanding leaders of the medical world that 80 to 85% of those seeking medical care could be skillfully and successfully cared for by a well trained general practitioner. The elamor for what the public ealls "socialized medicine" is in truth a demand for cheaper medical care. This demand has a foundation of fact in that the cost of illness is most apalling. Few can afford doctors, hospitalization and nursing eare for long illnesses. Some changes are inevitable. We know that "Government Medicine" is not the answer, Take the Veterans' Administration Hospitals. In Columbia, I am told, unofficially, the cost is between \$17.00 and \$18.00 per day per patient. The future county hospital may well be, of necessity, in the form of the general plan of the present day tourist camp. There could be a central medical station, with doctors, nurses and drugs, and the cottage occupied by patients with members of families doing much of the nursing, the dietary preparation and the laundry.

More physicians are needed in rural areas, but the truth of the matter is the medical graduate of today is unfitted to practice in small towns and rural districts as he is dependent on consultative services and on the help of laboratory technicians and other experts. Here is a remedy: in addition to the year of interneship, the medical graduate should practice, as an associate, with an established doctor, in a small town or rural community. In this way, he would gain, as under the old apprentice system, an understanding of his patients and experience in bedside practice that would be invaluable to him the rest of his life. It may be that after this, he should come back to take the State Board examination, and the examination should include questions on that experience. Such a plan would result in a more even distribution of practicing physicians between urban and rural communities. It is likely that many of these men would stay in the communities which they had served for a year, and no physician should be permitted to specialize until he has experienced five years of general practice.

It is not the purpose of this paper to contend that medical eare in all rural areas is sufficient, nor to imply that specially trained physicians and large medical centers are not necessary. They are essential for any system of medical care. There are many improvements that ean be made in rural medical practice and organized medicine should assist in better service. There should be provided, (1) better and more public health facilities; (2) more and better general district hospitals; (3) a maternity center for every county in the State; (4) at least one medical technician for each county; (5) a tuberculosis hospital for cach district; (6) better roads for all the people; (7) the prepayment plan of hospitalization for all the people for all types of illness; (8) State Hospital for Caneer; (9) a

large medical college to supply the needs of the State,

Some parts of this program would, no doubt, call for enlistment of federal aid. If so, it must be operated under local control. Under the program outlined above, and with the vast store of scientific knowledge at his command, the general practitioner need have no fear as to his future role in medicine. And he can teach the specialist to temper his knowledge with love of humanity; to put his emphasis on the patient and make science serve his ends.

At the turn of the century, when Doctor Browning began practicing, there was no such intricate webbery of complexities in society. European proletarianism had not made inroads into the American School of thought, especially the professional school, Commercialism, collectivism, and socialism were not major factors. The dollar mark was not the American insignia, bargaining was not collective—the individual counted. The professional man dreamed of a "high calling" and as his dream crystalized, it became a "magnificient obsession" that climaxed in making him the benefactor of mankind at large. Such a calling has been that of Doctor Browning. Doctor Browning is typified by Robert Louis Stevenson—"There are men and classes of men that stand above the common herd; the soldier, the sailor, and the shepherd not infrequently; the artist rarely; rarelicr still, the clergyman; the physician almost as a rule. He is the flower (such as it is) of our civilization; and when that stage of man is done with, and only remembered to be marvelled at in history, he will be thought to have shared as little as any in the defects of the period, and

most notably exhibited the virtues of the race. Generosity he has, such as is possible to those who practice an art, never to those who drive a trade; discretion, tested by a hundred secrets; tact, tried in a thousand embarrassments; and what are more important, Herculean cheerfulness and courage. So it is that he brings air and cheer into the sick-room, and often enough, though not so often as he wishes, brings healing".

And, quoting Sir William Osler, "And, finally, remember that we are useful supernumeraries in the battle, simply stage accessories in the drama, playing minor, but essential parts at the exits and entrances, or picking up, here and there, a strutter, who may have tripped upon the stage. You have been much by the dark river, so near to us all—and have seen so many embark, that the dread of the old boatman has almost disappeared, and

When the Angel of the darker Drink At last shall find you by the river brink, And offering his cup, invite your soul, Forth to your lips to quaff—you shall not shrink:

your passport shall be the blessing of Him in whose footsteps you have trodden, unto whose sick you have ministered, and for whose children you have cared".

Again I say, with all sincerity, I deem it a happy privilege to honor a man who has the esteem and love of so many of his own profession, as well as the hundreds and hundreds who call him, "my doctor",—Doctor Arthur Wolfe Browning.

5

Physiopathological Discussion of Jaundice in Early Life

M. W. Beach, M. D. and Clyde D. Conrad, M. D. Charleston, S. C.

Jaundice may be defined as an abnormal retention or regurgitation of bilirubin in the blood of sufficient quantity to stain tissue cells with a visible yellow coloration or to increase the bilirubin in the blood serum 2 or more milligrams per cent.

That we may have a clearer understanding of jaundice, it may be worthwhile to briefly review the formation of bilirubin. When the red cells are damaged or disintegrated they are taken up by the phagocytic

cells of the reticulo-endothelial system and the hemoglobin is broken down to its constituents, globin and heme. The globin is initially split off by hydrolysis. This leaves several molecules of heme or hematin. The iron is then removed from the heme, leaving the coloring pigment protoporphyrin. This molecule is then split at the a-methene bridge and two hydroxyl groups are added to the carbon atoms formerly joined by the methene bridge. The resulting molecule is bilimbin.

This product is carried to the liver for further synthesis. The byproduct is excreted into the intestinal tract as bile, where it is reduced or oxidized, partially reabsorbed for further synthesis, or is excreted in the feces or urine. The reduction of bilirubin forms urobilinogen or stereobilinogen which, when oxidized in the feces or urine, becomes stereobilin or urobilin. Normally, the adult daily excretes from 40 to 280 mgs.

of probilinogen in the feces and from 0 to 3.5 mgs. in the urine. During infancy and childhood, Josephs gives the following figures for fecal excretion of this product: first year, 13-30 mgs.; one to two years, 22-42mgs.; three to five years, 31 to 50 mgs.; and six to twelve years, 82-88 mgs. Since the liver is functionally concerned with all types of jaundice, we believe that it may be worthwhile to refresh our minds of its

multiple and complex physiologic functions before proceeding further with this discussion. We should recall that the liver is the largest organ of the body with a reserve of 80%. That the functional cells have marked regenerative properties and play a major role in the metabolic synthesis of carbohydrates, fats, proteins and vitamins. That it has to do with blood formation in the embryo and hematinic principles in the adult. That the liver produces fibrinogen, prothrombin, heparin and the blood serum proteins-albumin and globulin. That it stores copper, iron and glycogen. That it plays a role in the regulation of the acid-base balance, the heat production and the blood volume. That the liver acts as a detoxification center, secretes bile and excretes bile pigment. Therefore, any damage of this organ severe enough to cause clinical jaundice may alter, suppress or materially interfere with one or more of its complex physiological functions.

We have mentioned some of the liver's normal functions and have attempted to trace the normal sequences in the production of bile pigment, its synthesis in the liver, its excretion into the intestinal tract, its reduction and reabsorption, and its oxidation and excretion in the feces or urine.

All of us realize that jaundice is only a clinical manifestation of some physiopathological process which has progressed sufficiently to interfere with the normal detoxifying and excretory function of the liver. Therefore, we should attempt to find the causative agents and the mechanism responsible for this abnormal discoloration of tissue cells. In so doing, it may be worthwhile to consider the more common conditions of infancy and childhood that present jaundice as an outstanding clinical entity. It is with the newly born infant that we make our first acquaintance with jaundice and usually think little of its occurrence when seen on the second or third day, particularly if it appears to be mild in nature. But when there is early progression of a severe nature we become more apprehensive. The question then arises whether we are dealing with a simple icterus neonatorum, physiological icterus, or are we confronted with one of the more serious conditions. We are aware that the former causes little disturbance to the patient and disappears before the end of the second week, while the latter may terminate fatally before the end of the first week. Therefore, we should be conversant with the other common entities that may produce jaundice in the newly born.

With this idea in mind, we should give some thought concerning the possibility of the opposing Rh factors and different blood groups in expectant parents and should be mindful of the possibility of the mother having been transfused with blood which contained the antigens necessary to form certain hemoagglutinins. It is now customary for hospitals and most obstetricians to determine the Rh factor and blood type of the expectant mother. This is very valuable advance information which, if used conservatively, may pre-

vent catastrophe to mother and offspring. This information forewarns the doctor and he should set in motion such procedures as may be necessary to cope with the expected newly born baby.

If the mother is a primipara, has a negative Rh factor in her blood and the father has a positive Rh factor in his blood, the fetus may be of the normal or of the erythroblastic type. If the mother's blood is free or has a low titer of agglutinins during the last months of pregnancy, the chances are that the fetus will be normal and may have little or no jaundice. However, during the second or any subsequent pregnancy, by the same husband, the mother usually shows a rising titer of agglutinins in her blood during the last trimester of pregnancy and may give birth to a viable or nonviable offspring. Here the newly born may be jaundiced at birth, or it may develop during the first few days. The intensity of the jaundice increases rapidly and the patient becomes more icteric, listless, toxic, dehydrated, acidotic and soon passes out of the picture unless prompt and efficient measures are instituted in an effort to overcome this medical emergency. A similar picture may occur in the offspring of parents who have positive Rh factors in their blood, but who differ in the A - B blood types, the infant's blood type being different from that of the mother. When jaundice is seen in these infants. it usually occurs a little later and is of less intensity, but may persist for two or more weeks. Congenital hemolytic anemia occasionally may be seen during the early weeks of life, and when it occurs produces a severe degree of anemia and jaundice. Also, sickle cell anemia is quite rare during the early days of life, but some cases have occurred during the neonatal period. Malformation or atresia of the bile ducts should be considered as a probable cause for the production of jaundice during the early weeks of life. This is a progressive, intensive type of jaundice.

Syphilis, hemolytic and viral infections should receive due consideration. Expectant mothers often receive ante-partum transfusions which may act as the nidus for a viral infection in mother and offspring and thus cause an acute hepatitis which produces various degrees of jaundice. As time goes on, the infant is subjected to many types of infection, some of which produce clinical jaundice. The indiscriminate use of certain drugs and sometimes accidental poisoning may cause sufficient liver damage to disrupt its normal function and thereby produce a clinical icteric state. During childhood, occasionally we may see jaundice which is a part of the clinical picture of cirrhosis of the liver, or associated with neoplasms in or adjacent to the liver. Also, cholecystitis and cholelithiasis are seen in congenital hemolytic anemia in white children and sickle cell anemia in negroes. Parasitic infections should be mentioned, but are rare causes of obstructive jaundice. Severe jaundice encountered during early life is most likely a manifestation of one of the following connditions:

1. Icterus neonatorum severus. In our consideration of this form of jaundice, we wish to call to your attention that we are attempting to present a clinical entity somewhat different from the ordinary case of physiological jaundice which is thought to account for 98% of all ieteric states seen in the newly born baby. This form of jaundice, when it occurs in the normal mature infant, is ordinarily clinically evident by the second, third or fourth day. It is mild in nature, moderate in intensity, of short duration (less than two weeks) and produces a mild discoloration of the skin liken unto the vellow tint of a peach. There is little or no constitutional disturbance. The blood findings, other than an increased amount of bilirubin, are similar in character to those who do not show jaundice. On the other hand, the cases which we have designated icterus neonatorum severus develop their icteric states on the first, second, or third day of life. It is severe in nature, progresses rapidly for several days, the discoloration of the skin is intense and of a greenish-vellow tint. The constitutional symptoms develop early. The infant soon loses the desire to nurse, takes fluids only when forced and often vomits, becomes listless, drowsy, dehydrated and toxic. The stools are large, first meconium, then greenish-yellow, normal in number and in character. The urine is highly colored and may be positive for bilirubin and urobilin. The blood picture differs from that of the normal infant in the rapid and progressive destruction of the red blood cells with a rather high retention of bilirubin in the blood, the van den Bergh is usually biphasic. The temperature fluctuates a little above and below normal. There is an increased weight loss,

slow convalescence and the jaundice usually persists for several weeks. These infants are born to parents whose blood contains the Rh positive factor, but usually have a different A, B and O group from that of their offspring. Whether these or some other factors are the crux of the explanation for the severe type of hemolytic jaundice, icterus neonatorum severus, which we have attempted to describe, will be answered by further clinical study and research.

Now we will present two case histories which may give you a better clinical picture of this phase of jaundice.

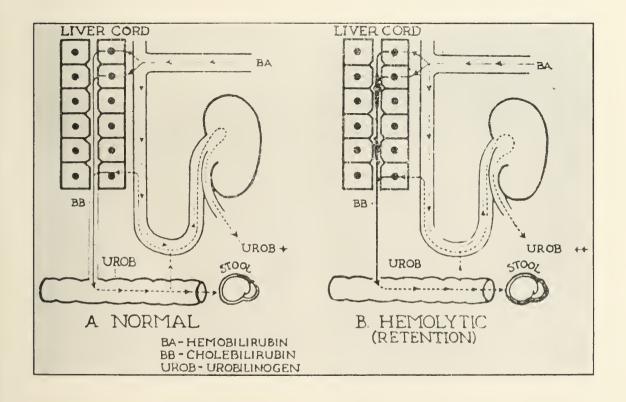
Case Number One.

Chief Complaint: Severe jaundice, vomiting, listlessness.

Present Illness: This newly born appeared to be doing well until the end of the second day, when she developed jaundice which increased in intensity during the following three or four days. She refused the breast and fluids, vomited several times and had two or three green, loose stools. She soon became listless and drowsy and showed evidence of dehydration

Past History: White female. Full-term, normal, spontaneous delivery. Birth weight was 8 pounds and 2 ounces. The third offspring.

Family History: The mother has always enjoyed good health and has never had any serious illness. The father is living and well, Mother's Wassermann is



negative. She has an Rh positive factor in her blood.

Physical Exam.: This revealed that the patient was a well developed and nourished infant who had carried on in the normal manner for the first 48 hours. She appeared drowsy, listless and showed evidence of dehydration and intoxication. The jaundice was very intense and the general appearance was that of a seriously ill newly born baby. The temperature graph was slightly above and below normal. Respiratory and cardiac rate was increased. Otherwise, the physical examination was noncontributory.

Lab. Exam.: Mother's blood has an Rh positive factor. Wassermann is negative. Blood group B. Baby's blood is Rh positive. Blood group AB. Icterus index 187 units. Van den Bergh, indirect ++++; direct ++. Urine positive for bilirubin and urobilin. Stools showed an increased amount of bile pigments. There was a fairly rapid destruction of red cells, more than a million per cubic millimeter in three days, but the total red cell count did not fall below four million per cubic millimeter.

Treatment: The patient was immediately hydrated with isotonic solution of sodium chloride and glucose. The nurse was instructed to administer one-half ounce of this solution between feedings. The baby's formula consisted of a high protein, high carbohydrate and low fat mixture.

Discussion: The infant passed a large amount of meconium for three days, then the stools became green and slightly loose for two days, and soft vellow thereafter. The weight loss was rather marked during the first twelve days and she did not regain her birth weight until the nincteenth day. The parenteral administration and the forcing of fluids was necessary to cope with the toxic, dehydrated and acidotic state. After she had received sufficient fluids electrolytes, her general condition slowly improved, but the severity of the jaundice remained about the same until after the tenth day. Then it slowly subsided during the following two weeks. The infant did not recover of the icteric state nor make normal progress until the fourth week. We believe that it may be logical to explain her van den Bergh and urinary findings on the basis of excessive production of bilirubin and the inadequacy of the fetal liver cells to take on their normal function whereby this pigment may have been excreted into the intestinal tract. According to Rich, it is reasonable to assume that with a marked increase of bile pigment carried to the liver for further synthesis and excretion, there is a probability that with this increased engorgement some of the liver cells may break down and release bile salts into the lymphoid channel and thence into the general circulation. This would explain the direct van den Bergh reaction. We have encountered in the pediatric and new-born services several cases similar to the one reported above. The question arises whether we should consider this a case of severe physiological or an abnormal type of hemolytic jaundice due to one of the atypical hemoagglutinins set up by different blood groups in mother and offspring. Some authors believe that this is the most logical explanation for these abnormal icteric states seen in infants where mothers and offspring have such blood types as was found in this case. They believe that there is a possibility of these types of red cells acting as proantigen which sets in motion the formation of isoagglutinins in the mother's blood and which may be transferred to the fetus and thereby cause agglutination and destruction of red cells, the severity of the jaundice being predicated on the time, titer and quantity of hemoagglutinins which have succeeded in passing into the fetal circulation.

Case Number Two.

Chief Complaint: Jaundice, anorexia, crying.

Present Illness: This newly born infant become yellow on the 7th day of life, and has gradually become more orange. Takes very little formula and cries continuously. Stools are yellow or green-flecked and urine is dark. Never vomits, nor has baby had diarrhea.

Past History: Full-term, spontaneous delivery, uncomplicated. Birth weight was 7 pounds, 12 ounces. Breast fed for 9 days, then put on formula for lack of breast milk. Has always nursed poorly.

Family History: Mother's Wassermann is negative. Rh factor not determined. Five previous pregnancies, the first 4 of which died at 2 or 3 weeks of age, and were jaundiced. The 5th child is alive and well at 3-years-of-age.

Physical Exam.:

Head: Fontanelles open and soft.

Ears: Membrane tympani pale and yellow.

Nose: Airway clear.

Eyes: Sclerae jaundiced. Pupils react to light.

Mouth: Normal mucosa. Tongue normal.

Neck: Supple. Thyroid normal.

Chest: Clear to percussion and auscultation.

Heart: Not enlarged to percussion. No murmurs. Rapid and regular. P2 greater than A2.

Abdomen: Soft and non-tender. Liver 4 cms. below right costal margin. Spleen not felt.

G. U.: Scrotum (?) bivalved. No testes present. Penis (?) (or large clitoris) with urethral orifice on under surface. No vaginal orifice.

Extrem.: Normal.

Reflexes: Physiological.

Skin: Intensely jaundiced. Moderately dehydrated.

Lab. Exam.: (On admission)

R. B. C.-5 million; hemoglobin-13 gms.; W. B. C. -14,300; differential-normal. Icterus index-108 units. Van den Bergh ++ direct; +++ delayed direct. Wassermann and Kline-negative. Fragility test-within normal limits. Stool-urobilin and urobilinogen present. Blood type "O". Rh factor positive. Mother's Rh factor positive.

Hosp. Course: There was a gradual fall in red blood cells and hemoglobin for 5 days and a sudden fall on the 6th day (to red blood cells—2.8 million; hemoglobin—7 gms.) with sudden circulatory collapse and air hunger. Required venesection and immediate transfusion, followed by repeated small transfusions and maintenance of hydration. Gradual loss of jaundice and decrease in the size of the liver until the twelfth hospital day, when there was a sudden onset of Cheyne-Stokes respirations and lethargy without other clinical evidence of intracranial hemorrhage. Red blood cells were 4 million; hemoglobin 12 gms. Icterus index was 20 units with van den Bergh reaction unchanged.

Comment: Oxygen, stimulants and artificial respiration failed to restore normal breathing. Died on the twelfth hospital day. Clinical cause of death kernicterus.

Final Diagnosis: (By autopsy)

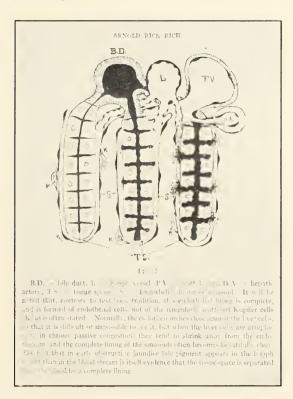
- 1. Female baby, shown by uterus, tubes and ovary with imperforate vagina.
 - 2. Interstitial pneumonia.
- 3. Strangulation of chorioid plexus with hemorrhage.

II. Congenital obliteration of the bile ducts. This malformation of the bile ducts is probably the result of an arrest in the development of the biliary ducts. There may be an absence or an early obliteration and cord-like formation, instead of the usually patent biliary ducts in which there may be an absence or an atresia of the hepatic ducts, an atresia or stenosis of the common duct, or various other malformations of this system. The jaundice in cases of biliary atresia during the first few days of life may present all the common ear marks that are found in the normal infant of a simple icterus neonatorum. On the other hand, some of these cases do not develop clinical jaundice until after the first week, but when the icteric state has become evident, it is without remissions and slowly increases in intensity and the skin assumes a greenish-yellow, bronze color which is commonly seen in cases of complete obstruction of the biliary tract. The constitutional symptoms are mild and the patient does not appear to be distressed and usually takes formula and fluids well. The stools are of the acholic type. The urine is intensely bile stained. The liver soon becomes enlarged and its firm, smooth edge can be palpated 6 to 8 cm. below the costal margin. Later, the spleen becomes enlarged. The van den Bergh test gives a direct reaction. The icterus index varies from 50 to 350 units.

These patients may survive for months, but when the diagnosis has been established and the general condition of the patient is satisfactory, an exploratory laparotomy should be performed because 20% of these patients have malformations which may be corrected by surgical means. However, the small number of cases that we have encountered were not amenable to surgery. We will report one of these case histories.

Case Number Three.

Chief Complaint: Jaundice of the progressive type; rash on face.



Present Illness: This seven-weeks-old white male infant is said to have been jaundiced at birth, which has steadily become more intense. Seldom vomits—nor is vomitus ever bile stained. Mild constipation. Stools are usually of normal color, but sometimes are chalky white. Has had rash on face for the past two weeks.

Past History: Full-term, forceps delivery. Birth weight was seven pounds and two ounces. Has gained weight—now weighs eight pounds and two ounces. Put on formula at age of four days because of sore breasts and inadequate supply.

Family History: Mother and father living and well. Veneral history negative. No abortions. One sibling of six years, living and well. Not jaundiced at birth. Physical Exam.: This was a fairly well developed and nourished infant who had the facies of being unwell, but showed no acute distress. There was a fine, petechial rash on forehead and face.

Head: Anterior fontanelle open. Posterior closed. No abnormal findings.

Ears: Membranae tympani colored vellow.

Nose: No discharge.

Eyes: React to light, Scherae intensely yellow, Some icteric color of tears.

Mouth: Mucous membranes icteric. Tongue coated. Pharvnx clear.

Skin: Some petechial rash on face and forehead and the skin is intensely jaundiced.

Neck: Supple. Thyroid apparently normal.

Chest: Clear to percussion and auscultation.

Heart: Rapid. Regular. Apex beat in the 4th interspace inside the midclavicular line. First and second sounds clear and distinct. No murmurs noted.

Abdomen: Flat. Liver palpable four or five cms. below the costal margin. Spleen not felt. No masses felt.

G. U.: Normal. Testes in scrotum. No phimosis.

Reflexes: Physiological.

Lab. Exam.: Blood—R. B. C., 3.2 mil.; W. B. C., 14,050; hemoglobin, 8 gms.; P. M. N., 26; lymp., 62; mono., 4; cosin., 7; bas., 1; l nucleated RBC 100 WBC. Van den Bergh, direct ++++; delayed direct ++++. Infant's blood type was IIA. Mother has Rh positive factor. Baby was Rh positive. Prothrombin time, bleeding time, coagulation, total and fractional serum proteins—all within normal range. Wassermann and Kline—negative. Feces—negative for bilirubin.

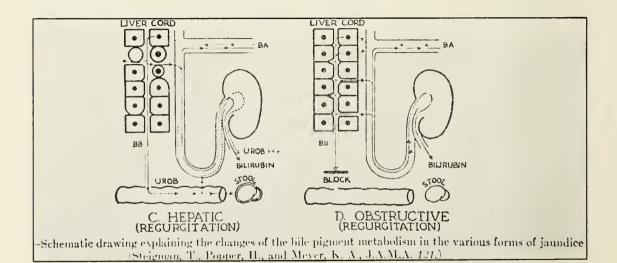
Urine—negative for urobilin and urobilinogen; positive for bilirubin.

Hospital Course: Temperature varied from 99° to 100° before operation. Patient given transfusions of fresh blood, vitamins and vitamin K. Stools were pasty white, although occasionally stained on surface with yellow, questionably bile. During the pre-operative period, he gained eleven ounces. Exploratory laporatomy revealed that there was no demonstrable gall bladder nor bile ducts. The patient stood this operation poorly. The post-operative course was steadily downhill, with the jaundice increasing in intensity. He became toxic and vomited. Took fluids and food poorly after the operation and died on the fourth post-operative day.

Comment: This patient was a rather poor surgical risk, but on account of the possibility that he might be one of the twenty per cent which could be relieved by surgical means, the attending physician and surgeon felt that he should be given the benefit of an exploratory laporatomy.

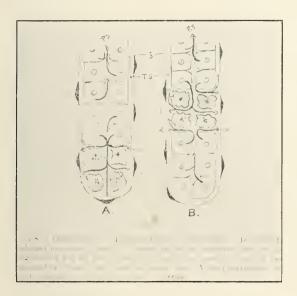
Final Diagnosis: Congenital atresia of bile passages.

111. Septicemia. Since the advent of the sulfonamides, penicillin and streptomycin, there has been a marked reduction of sepsis in mother and offspring which is partially responsible for the decline of the icteric state encountered in this type of case. The most frequent etiological agents of these cases are: the streptococcus, pneumococcus, staphylococcus and the colon bacillus. These infections may occur prenatally or postnatally. Probably the most frequent portal of entry is through the cord and skin. These infants are acutely and seriously ill with high fever, rapid pulse and respiration, are drowsy, irritable and often refuse to nurse or take fluids. They soon become toxic, dehydrated and acidotic. The icteric state in these cases adds to the gravity of the situation. However, with the present day therapy of the sulfonamides and anti-



botics and a better understanding of the importance of fluids and electrolytes, blood and plasma, and improvement in the technique of administration, we may now rescue some of these helpless individuals.

IV. Congenital Suphilis. This tragedy of the newly born infant in which jaundice, anemia, edema and osteochondritis are the predominating symptoms is less frequently encountered than in former days. However, we should always be mindful of the possibility of this disease and of its bizarre manifestations, which may be very similar to other icteric states encountered in the infant during its early days of life. It may cause confusion and simulate sepsis, biliary dysfunction, erythroblastosis, etc. These types of cases usually oceur of pregnant mothers who have a severe syphilitic infection and who have received no antisyphilitic treatment, or received treatment very late in pregnancy. Since this form of jaundice presents such a variegated pattern, we will attempt to cover a portion of its vagaries with a case report.



Case Number Four.

Chief Complaint: Jaundice; discharge from nose; swollen scrotum.

Present Illness: This six-weeks-old colored male infant took sick two or three days ago with fever, fretfulness, discharge from nose, yellowish color of skin and swelling of scrotum. Stools normal in number and yellow in color.

Past History: Full-term, normal, spontaneous delivery. Birth weight was seven pounds. The neonatal period was uneventful. Breast and bottle fed.

Family History: This was the mother's first pregnancy. No difficulties and has enjoyed good health. The father is in good health and has never had any sickness. Both denied all veneral diseases, but have never had blood test.

Physical Exam.: Acutely and seriously ill infant who is cross and irritable and refuses to lie in the supine position.

Head: Anterior fontanelle open and full; posterior closed.

Ears: Negative.

Eyes: Pupils react to light. Sclerae vellow.

Nose: Seropurulent discharge.

Mouth: Clean. Mucous membranes pale with yellow cast.

Neck: Thyroid normal.

Chest: Fairly well aerated. Few mucus rales throughout the two sides.

Heart: Apex beat in the 4th inter space inside midclavicular line. First and second sounds clear and distinct. No murmurs noted.

Abdomen: Liver enlarged and palpable 5 cms. below the costal margin. Spleen palpable at costal margin.

G. U.: The right side of scrotum was enlarged, cdematous and slightly ulcerated.

Extrem.: Appeared to be normal.

Reflexes: Physiological.

Skin: Dry and intensely jaundiced.

Lab. Exam.: (On admission)

W. B. C., 3,200; R. B. C., 1.24 million; hemoglobin, 3.75 gms. There was no sickling of red blood cells. Icterus index was 142 units. Van den Bergh was ++++ direct. Rh factor of mother and child were positive. Mother's and father's Wassermann and Kline were ++++. X-ray of long bones showed no evidence of syphilis. Spinal fluid Wassermann was positive +++++, and contained 2,328 cells with 95% polys. Total proteins 190 mgs. Sugar 15 mgs. Two spinal cultures negative.

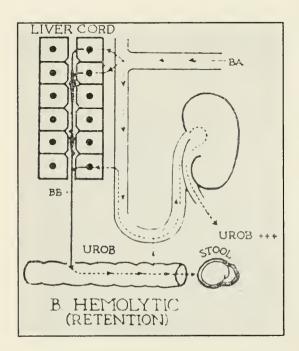
Hospital Course: The infant was transfused with blood and given penicillin therapy. His general condition improved and he was less irritable. Jaundice was less intense and in nine days the icterus index had dropped to 22 units. On account of the continuance of the high cell count and high proteins in spinal fluid, some meningitis other than syphilis was thought to be present. Spinal culture continued to be negative. The temperature was 99° to 103° for 2½ weeks, then slowly subsided to normal. Treatment during this period included sulfadiazine and dicumerol therapy. After this time, he was placed on anti-syphilitic regime. He also received accessory food factors. After thirty days of hospital treatment, there was no evidence of jaundice. The liver was only 2 cms. below costal margin. Hemoglobin and R. B. C. had returned to normal. Other than positive Wassermann and Kline,

the spinal fluid was normal. The blood Wassermann and Kline continued to be positive.

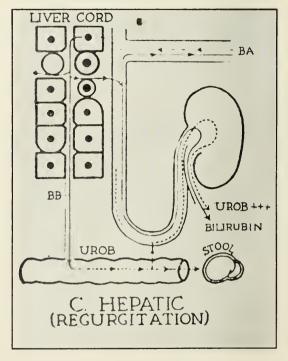
Final Diagnosis:

- 1. Congenital syphilis.
- 2. Syphilitic hepatitis with obstructive jaundice.
- 3. Anemia, severe, secondary.
- 4. Meningitis, type undetermined.

V. Eruthroblastosis foctalis. This clinical entity in which jaundice, anemia and sometimes edema, singly or combined, present the hall-mark for the most serious and fatal hemolytic disease encountered in the newly born infant. Most infants are very fortunate on account of the low incidence of this grave type of jaundice. Only one occurs in every two or three hundred births. However, these figures vary greatly in different communities. Even though the incidence is low, the mortality is more than 50%. Therefore, we should anticipate the seriousness of these icteric states which may occur in some of our newly born babies whose parents have not had the advantage of blood study. To Landsteiner, Wiener, Levine and others goes the credit for the scientific work and clinical application whereby 90% of these forms of jaundice may be classified according to their ctiology. However, there is still a missing link and 10% of these cases are without adequate explanation in which the mother may be Rh positive, or the baby Rh negative, etc. Therefore, it is now conceded that in most instances erythroblastosis foetalis in all of its forms, and there are many, is based upon the immunization of the Rh negative mother by the Rh positive red cells of the foetus or by previous transfusion with this type of cell. Most of the expectant mothers react to these



antigens and produce a soluble anti-agglutinin which passes into the foetal circulation and there causes agglutination and destruction of red cells. The resultant jaundice is dependent on the time and amount of agglutinins produced in the mother and when the foetal circulation becomes susceptible. The mother's response to this antigen varies considerably and some do not respond at all. Therefore, the different types of response encountered in mothers may be the factor responsible for the marked variance of symptoms seen in this disease. In the grave form the pattern is dominated by a general anasarca which appears to be puffy and pitting in nature and extremely marked about the eyes, lips and face. The abdomen is distended and often tense. The skin is edematous, lacks continuity and is of a greenishvellow color. The anemia is of sufficient grade to speed up the respiratory and cardiac response. The heart is enlarged and presents various types of murmurs. The liver and spleen are very much enlarged and are resistant to palpation. There is a sub-normal response of the patient to the examination and the examiner is impressed by the gravity of the situation. The erythrocyte count and hemoglobin are about one-third of the normal. There are frequently more than 10,000 nucleated red cells, also a large number of reticulocytes. The platelets are generally reduced in number, the bleeding time is prolonged. The prothrombin may be deficient. The van den Bergh is biphasic and the stools may become clay colored during the first week, should the patient survive. On the other hand, if the edema is absent and the jaundice and anemia develop more slowly in the first few days of life, the infant's chance of survival is increased very much. Of course,



this statement is somewhat predicated on the efficiency and promptness in which we meet this medical emergency. In further consideration of this icteric state, we believe that it may be worthwhile to impress the physician with the accumulated evidence which suggests that there are many types of erythroblastosis foetalis of varying degrees of severity and that the greater majority present a more favorable picture and some recover with meager or without treatment.

We have attempted to refresh your minds with certain data pertinent to this form of jaundice and now will present a clinical case which somewhat conforms to the latter group.

Case Number Five.

Chief Complaint: Severe jaundice anticipated.

Present Illness: Newly born white female infant weighing 7 pounds, 4½ ounces. Born of parents with known Rh factor incompatibility. Full-term, spontaneous delivery in hospital January 31, 1947, the patient being closely observed for possibility of erythroblastosis fetalis.

Family History: The mother is 42-years-of-age. She is Rh negative. The father is Rh positive. Seven living children, 2 abortions and the last 5 infants were born alive, but died with jaundice. Excluding 2 abortions, said to be due to malaria plus medicine and fall on abdomen in that order of gestation, the past 5 pregnancies produced infants who developed jaundice on the third day of life and died in 3 days, 6 days, 5 days, 16 days and 3-months-of-age respectively in the order of birth. Mother's anti-Rh factor agglutinin level followed during the last 6 months of this pregnancy was as follows:

9 / 7 /46 positive 1-4 dilution

11 / 8 /46 positive 1-16 dilution

1 / 4 /47 positive 1-4 dilution

1/31/47 positive 1-1 dilution (about 7 hours before delivery).

2/24/47 negative in all dilutions (about $3\frac{1}{2}$ weeks after delivery).

Mother's veneral history is negative and Wassermann and Kline is negative. Mild toxemia of pregnancy with last 5 pregnancies and with this one, as evidenced by blood pressure of 142 70 to 160 100, vertigo and 7 to 10 pounds weight gain during the last month before delivery. No albuminuria or edema at any time with this pregnancy. Seven siblings, living and well; 26 years, 24 years, 21 years, 16 years, 13 years, 11 years and 8 years of age.

Physical Exam.: Apparently healthy, newly born female infant, without jaundice. Temperature 98° F. Both fontanelles open; not bulging. Head 13½" in circumference, shoulders 14½", chest 14", length 18½".

Ears: Normal.

Nose: Normal.

Eyes: Sclerae easily seen and not jaundiced. Pupils react to light.

Mouth: Mucous membranes pink. No hemorrhage. No malformations.

Neek: Supple. Thyroid apparently normal.

Chest: Clear to percussion and auscultation.

Heart: Rate rapid and regular. No murmurs. Apex beat inside midelavicular line.

Abdomen: Flat. Not distended. No bleeding from cord. Liver palpable under costal margin. Splcen not felt.

G. U.: Normal female.

Extrem.: No deformities. Nails good color.

Reflexes: Physiological.

Lab. Exam.: (First hospital day)

R. B. C., 4.37 million; hemoglobin, 17 gms.; W. B. C., 17,300; polys., 61, lymph., 36; mono., 3. Eight normoblasts per 100 W. B. C. Reticulocytes 12%. Normocytic, normochromic. Blood type A. Rh factor determination positive. Anti-Rh factor agglutination titre negative in all dilutions. Urine dark orange yellow. Kline negative. Patient matched and crossmatched with Rh negative donor; no blood given. Patient given vitamin K, mgms. 5 daily for 3 days. No breast feeding permitted. Placed on formula of evaporated milk, 6 ounces, 2 tablespoons Karo syrup, boiled water, 9 ounces, given in 6 feedings daily.

Hospital Course:

Second hospital day—R. B. C., 4.30 million; hemoglobin, 17 gms.; W. B. C., 15,500; polys., 61; lymph., 36; mono., 3; normoblasts/100 W. B. C., 0; Reticulocytes, 6%. Normocytic, normochromic. Weight 6 pounds and 15 ounces. Patient developed a slight icteric tint to sclerae. Passed one meconium stool. Liver 2 cms. below costal margin. Spleen 4 cms. below costal margin. Given 60 cc. transfusion of Rh negative blood, and 75cc. of 2½% dextrose in half normal saline subcutaneously.

Third hospital day—Hemoglobin, 16 gms. Patient intensely jaundiced, vomited most of every feeding, passed three meconium stools and was silghtly distended. Karo in formula reduced to 1½ tablespoons, seventy-five cc. transfusion of whole blood, and 75 cc. of 2½% dextrose in half normal saline subcutaneously given. Liver and spleen still 2 cms. and 4 cms. respectively below costal margin in nipple line, and remained about this position throughout the hospital course. Skin, sclerae and nueous membranes all appear intensely jaundiced. Weight 7 pounds, 2 ounces.

Fourth hospital day—R. B. C., 5.15 million; hemoglobin, 18; W. B. C., 9,300; polys., 71 (14 n.f.); lymph., 27; eos., 2; normoblasts, 0; reticulocytes, 4%. Jaundice, spleen and liver size all unchanged clinically. Abdomen more distended, but after being relieved by rectal tube, patient took formula well and passed 3 soft, yellow stools. Eighty ec. fluids given subcutaneously twice. No blood.

Fifth hospital day—R. B. C., 5.90 million; hemoglobin, 17 gms.; W. B. C., 12,000; polys., 68 (10 n.f.); lymph., 29; mono., 2; eos., 1; normoblasts. 0; reticulocytes, 5%. Degree of jaundice and position of liver and spleen unchanged. Continued to take formula fairly well, vomited once. Sixty cc. of subcutaneous fluids given twice. Two soft, yellow stools.

Sixth hospital day—R. B. C., 5.80 million; hemoglobin, 17 gms.; W. B. C., 13,000; polys., 62 (4 n.f.); lymph., 32; mono., 5; eos., 1; normoblasts, 0; reticulocytes, 5%. Appeared less jaundiced, took formula without vomiting. Position of liver and spleen unchanged. More alert. Better coloring. Subcutaneous fluids given twice. Stools well colored.

Seventh hospital day—R. B. C., 4 million; hemoglobin, 15 gms.; W. B. C., 14,600; polys., 58 (6 n.f.); lymph., 39; mono., 3; normoblasts, 0. Patient continued to take formula well with a total of 10 ounces. No parenteral fluids or blood. Took 6 ounces dextrose in saline between feedings.

Eighth hospital day-R. B. C., 5 million; hemoglobin, 14.5 gms.; W. B. C., 17,000; polys., 52 (12 n.f.); lymph., 46; mono., 1; eos., 1; normoblasts, 0. Weight 6 pounds, 153/4 ounces. Sickle-cell study showed no sickling in 48 hours. Hematocrit study-M. P. C., 47 cmm; M. C. V., 94; M. C. H., 29; V. C. H. C., 30; vol. index-1.02. Bleeding and clotting time, normal. Urinalysis essentially negative. Icterus index-133.3 units, van den Bergh, direct +, indirect +++, platelets 250,000 cmm, R. B. C. fragility test,-normal resistance to hemolysis and same as controls red blood cells. Patient began a slow, but steady, improvement from this date on. Took formula well and there was a continuous, but slow, gain in weight. Daily blood counts done until the 13th hospital day and twice weekly after that without significant change in count or smear.

Jaundice diminished slowly clinically and was not discernable by the 20th hospital day. Transfusion of whole blood was given on the 18th hospital day because of an R. B. C. of 3.50 million and hemoglobin of 10 gms. Response to this transfusion was good, with a rise in R. B. C. to 5 million and hemoglobin to 14 gms. Patient discharged on 31st hospital day in good condition, but with spleen and liver still palable below costal margin, and she had just regained her birth weight.

Comment: This case was notable first because of mother's history of increasing infant longevity before demise in preceding 5 infants and mother's decreasing titre of anti-Rh factor antibodies as labor approached. It raised the question of the mother becoming descnsitized to the Rh factor, or other hypotheses for this phenomena. Secondly, this infant, like the others according to history, was not jaundiced at birth and also we were never able to find normoblasts. The reason for this is not clear. However, in view of Rh factor determinations and jaundice, we feel justified in placing this case with those usually labelled erythroblastosis fetalis or hemolytic anemia of the newborn. Patient seen in clinic three times since discharge and at 3 months of age has no clinical jaundice. Liver edge palpable at the costal margin. Spleen 4 cms. below costal margin. Blood count shows R. B. C. of 3.69 million and hemoglobin of 10 gms. Weight is up to 11 pounds, 14 ounces, and she is apparently in good health.

Final Diagnosis: Erythroblastosis fetalis.

From Department of Pediatrics, Medical College of the State of South Carolina—M. W. Beach, M. D., Professor of Pediatrics and Clyde D. Conrad, M. D., Teaching Fellow.

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Coronary Occlusion

A Therapeutic Contribution W. Tertsh Lander, M. D. Williamston, S. C.

The frequent careful autopsy reports leave little to desire for a sure diagnosis. In this line only one thing will be presented, and that as a corollary near the end.

In reading these reports we arrive at the conclusion that only one in ten has an actual plugging of the artery. How to manage this ten per cent is thoroughly dealt with in the books, and cannot profitably be discussed here. It is with the 90% we wish to deal. The dangerous ischemia is usually the result of calcium poverty of the blood. If this is corrected, recovery may be expected. Such a case is likely to become chronic, and may need daily supply of calcium indefinitely. Otherwise an acute exacerbation may bring an untimely end. In giving calcium, of course a sufficiency of Viosterol must be included. Several of our best drug houses furnish such a tablet or capsule. There may be habitual call for from two to four a day.

A case in point: W. T. was presented, with classic symptoms of impending death-without pulse or color, and unable to speak. Usual emergency measures were adopted, and conventional care was carried out serupulously for two weeks. By this time the calcium deficiency was noted. Calcium viosterol wafers were given freely, and graduated exercise was allowed. After six weeks the patient was found in the blacksmith shop seeing about an urgent job. The blacksmith apologized for the absence of his indispensible striker. My impatient patient took the striker's sledge for twenty minutes. No harm came of it. Since then his amusement has been with sledge hammer, grubbing hoe, wood saw, ax-or other cardiac inhibitoryaccording to whim. BUT IIIS CALCIUM HE NEVER OMITS!

A form not recognized by most of us specialy calls for attention. The patient looks right, simply complaining that his strength leaves him and he feels utterly let down. Of course, the electro-cardiograph will settle the question; but the ordinary doctor has no such help. Instead, take the coagulation time. Be sure you take it right. This may be twice the normal or more. Start the calcium and watch the pulse. The change in fifteen minutes may surprise one. Such cases are common. They are incompetent for work, and usually are looked upon as lazy. The laziness is conservative; under hard work they may drop dead. They are safe and may do what they please so long as they keep their calcium sufficient.

Again: The hysteria (?) which often intrudes in any illness will frequently be found to be nerves on the raw for lack of calcium,—an incipient Coronary Occlusion.

The coagulation test is of such fundamental value in these eases that a word here may be worthwhile. The simplicity does not excuse carelessness. It must be done right. Perhaps best for the ordinary doctor is the following method: Take a small Petri dish (or its equivalent from the kitchen). Have in the dish a few drops of water to insure a moist atmosphere. Very carefully clean and dry the underside of the cover. Sterilize the finger scrupulously; dry it before striking with a rather coarse hypodermic needle. Strike deep enough so that little or no squeezing is necessary. Place a large drop on the underside of the cover. Note carefully the time to the second. Tally each 60 seconds. After two minutes, from time to time, test the coagulation, passing a fine pointed pin through the drop. A hypodermic needle does not serve accurately. By this method 150 seconds may be called normal.

What's New

GASTRO-ENTEROLOGY

Hugh Smith, M. D. Greenville, S. C.

With only six minutes allotted for this part of the program it has occurred to me that a brief review of a book published in 1943 would be profitable. All of us read, from time to time, something that strikes us individually as really fine.

"Human Gastrie Function", Wolf & Wolff, Oxford University Press—1943—is to me a really fine book, a magnificent contribution to medical literature. An understanding and appreciation of physiology is admittedly basic in the study of pathology. Our interest in and appreciation of emotional influences has broadened our clinical usefulness. Psychosomatic disease is indeed an important part of our days work as clinicians.

"Human Gastric Function" is a report of a long experimental study of a man and his stomach by Stewart Wolf, Capt. M. C., A. U. S. and Harold G. Wolff, M. D., Associate of Medicine, Cornell University Medical College. In the introduction the authors review briefly the important contributions of Beaumont in 1833 in his studies of Alexis St. Martin. Beaumont's interest was largely with the gastrie iniee and its influence on the ingested foods. Richet, who in 1878 studied an early gastrostomy patient, was mainly interested in the chemical and physiological properties of gastrie juice. Carlson, in 1912, with a similar patient, was primarily interested in kinetics and the majority of his experiments concerned motility and hunger contractions. Pavlov, in 1910, had shown the effects of environmental influence on gastric function of experimental dogs. Connor, who probably has exerted the greatest influence on clinical medicine of any physiologist, in 1909 published some of his works on 'The influence of emotional states on the functions of the alimentary eanal.'

The significance of psychosomatic relationships looms large in clinical problems today. It is from this vantage point that Wolf and Wolff have made such a brilliant contribution.

The subject of his work, Tom, was 57 years old, of Irish stock and a person with some insight and of an independent nature, subject to the same emotional and physical influences of an average working man with a family. At the age of 9 Tom drank some extremely hot clam chowder and as a result an oesophageal stricture, resistant to dilatation, occurred. Gastrostomy was necessary and from that age on Tom

fed himself through the operative stoma. He learned quite early that by chewing his food before funnelling it into his stomach that he could maintain good digestive health. As a boy he was active in school games and as an Irishman not averse to a fight. He smoked a pipe moderately and drank a few beers, of which he would swallow a small amount to be regurgitated before pouring the rest directly through his funnel. He did not use much whiskey because small amounts spilled around the stoma irritated the granulating tissue surrounding it. He learned that it took about five hours for a meal to be digested and clear his stomach, and noted that liquids were generally digested quieker than solids. He found that meats required 6-9 hours and that leafy vegetables remained in his stomach for 10-12 hours. He fed himself twice a day and found it wise to wait 6 or more hours between feedings to prevent the reflux of stomach eontents on uneovering the stoma to feed again.

In this case there was a defect midway between the xiphoid and umbilieus, 3.5 em in diameter, through which herniated a collar of gastrie mucosa about 10 cm across. It was possible to replace all of this tissue through the opening and to maintain it in place by a pressure gause bandage between feedings and studies. It is remarkable indeed that Tom was free, generally, of all so-ealled chronic indigestion. He had no evidence of chronic gastritis and no ulcerations. The stoma was large enough to allow the introduction of a lighted *scope* for direct visualization and even for photography. Specimens could be withdrawn at will so it is evident here indeed was an ideal situation to study Human Gastrie Function and the authors were splendidly equipped in every way to do so.

Each chapter details an experimental study and the conclusions derived therefrom. Of course, as the authors point out, these studies were done on one human stomach. But the fact that this man had lived a fairly normal life since age 9 with his gastrostomy, and that he was a rather normal individual with the usual ups and downs, make it reasonable to believe that the conclusions drawn are, to all practical purpose, generally accurate.

This book reports a monumental contribution and I recommend it to you as something fine that you will thoroughly enjoy.

SIGNIFICANT RECENT ADVANCES IN OBSTETRICS

J. DECHERD GUESS, M. D. Greenville, S. C.

The most significant of the several recent advances in obstetrics consists in a greatly improved realization of the importance of proper nutrition during pregnancy. Not only has there occurred more wide spread and more profound realization of the ill effects of improper nutrition, but there is equally wide spread and more profound acceptance that proper nutrition has numerous and significant good effects. Along with this has come a better understanding of the component elements of diet designed to furnish adequate nutrition and a clearer understanding of why these diets furnish the adequate nutrition they do.

A pregnant woman expends more work-energy than does a non-pregnant woman. Consequently her caloric requirements are definitely greater, (about 20 per cent in the second half of pregnancy) than they were before pregnancy. The non-pregnant woman requires about 2200 calories, while the gravida should have 2500. However, to supply these caloric requirements alone is not sufficient. There are specific and peculiar requirements regarding the kind of food. Her own personal requirements include an increased protein intake to furnish and to replenish energy and to equalize her protein metabolic ratio.

She also requires protein with which to build her baby's body. The daily protein requirements in the second half of pregnancy is 85-100 grams as compared with 60 gm, in the nongravid woman.

On the other hand her carbohydrate and fat requirements are not only not higher but are actually lower than before pregnancy, and excess intake during pregnancy results in stored fats within her own body and that of her baby with weight increase and consequent unnecessarily increased burden upon her circulatory system, her excretory system and her skeletal system.

There is an increased need of vitamins and minerals to meet the requirements of her and her baby.

Therefore the present concept is that a pregnant woman requires a diet high in proteins, rather low in carbohydrates and quite low in fats, but rich in minerals, especially calcium and iron, and very rich in vitamins—all of them.

There is much published and unpublished experimental work on diet in pregnancy. Within the next year or so there will be probably much more. Dr. Lull and his group in Philadelphia began their studies before the war, they were interrupted by the war and have just recently been resumed. This group

has some very definite ideas, with supporting figures, regarding the benefits of a good diet in pregnancy. Dr. Lull believes that it has reduced almost to nil their toxemias of late pregnancy, has eradicated their symptoms of circulatory, muscular and emotional exhaustion, that it has made for longer, stronger babies, of more adequate weight, that it has greatly reduced the incidence of premature labors, and that it has hastened convalesence after delivery.

The Harvard group has found that a similar diet has similar beneficial effects. An exhibit describing a good diet in pregnancy has been arranged by Dr. Hilla Sheriff of the M. C. H. Division of the State Board of Health and her co-workers and you will find it interesting and instructive. As a part of a diet such as this there should be included one or more capsules of therapeutic, (in distinction from prophylactic) multi-vitamins. A good capsule of this type is Upjohns Zymacaps.

Perhaps, the next most significant recent advance in obstetrical knowledge has to do with the maternal and infantile effects of heterology in father and mother with regard to the Rh factor and certain other more rare blood factors. Because of this knowledge, it is now just as important to test for the Rh factor as it is to test for syphilis in early pregnancy. Rh negative women should not receive blood from Rh positive donors, nor should they mate with Rh positive men, and if they do they should avoid parenthood. The pediatrician should make special preparations to receive a child from such a mating. It is strongly likely to have congenital jaundice or massive edema, it may be stilborn or die shortly after birth, and the incidence of deformities is very high.

The last advance that can be mentioned in this short discussion and that only briefly is the increased availability of specific chemotherapy for treatment and prevention of puerperal sepsis. Penicillin is easily available and is relatively inexpensive. Penicillin in oil and wax makes office and home treatments practical. Sulfadiazin has relatively fewer side effects and is usually much better tolerated than were the earlier sulfa drugs. These agents have proven almost as dramatic in the treatment of post-abortional and post-partum infections as they have in the treatment of pneumonia. Streptomycin has just become available. It promises to be highly useful in a small group of infections of pregnancy and the puerperium not responsive to sulfanamides or penicillin. B, proteus urinary tract infections are important examples.

The Journal of the South Carolina Medical Association

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JANUARY, 1948

JAMES McLEOD

In the passing of James McLeod, South Carolina lost one of her leading citizens, our Association lost one of her most aggressive leaders, and his colleagues lost one of their most valued and loyal friends. His sudden death came as a great shock to those who knew him and expressions of sympathy and of appreciation for his life and work poured in from every section of the state.

Of the many tributes which were written we have selected the one which we believe would have appealed most to him were he living, since it appeared as an editorial in his home-town paper, the Florence Morning News. It expresses the sentiments and feelings of those who knew him best and loved him most, the people of his own community.

"This community has been deeply shocked and grieved by the sudden death of Dr. James McLeod. He was so much a part of Florence and had rendered such a conspicious service to this entire section of South Carolina that his passing leaves a very great yold which will be exceedingly difficult to fill.

"Dr. McLeod's ehicf claim to recognition was as a physician and surgeon. He was the son of a father of equal distinction who founded Florence's McLeod Infirmary and developed it into one of the leading such institutions in the South. Dr. James, as he was commonly ealled, had himself been active superintendent and chief surgeon since 1935. In this eapacity he had carried on in a manner satisfactory to all the great work of his father. Moreover, he had earned wide recognition in his profession, being named to membership in numerous national medical societies and elected president of the South Carolina Medical Association.

"Two years ago when a back ailment made it clear that he would have to discontinue surgery, Dr. Mc-Leod eaught a vision of serving his state. He was like that. If the door to service closed in one area, he would turn to another. And in whatever direction he spent his energies, he did so with complete abandon. Entering the race for governor, he threw himself into the campaign with all of his mental and physical powers. The result was a magnificent campaign in which he polled great support throughout the state, and as a result of which he firmly planted himself in the state's political picture. One of two things was certain. He would either bide his time and offer for governor at the next election, or he would throw himself into the race for United States Senate. Certain also was that whichever race he entered, he would have an excellent chance of victory.

"Dr. McLeod was no self-seeking politician. Those who knew him best knew that he aspired to serve his state and his nation as a statesman would. In the governor's mansion or the United States Senate, he would have rendered an able and fearless service to his people. That death intervened and prevented the realization of these aspirations is the state's and the nation's loss.

"It is doubtless true that the heavy responsibility he had carried as superintendent of the hospital, as citizen of Florence, and as one who aspired to serve his state and nation contributed to the heart attack which proved fatal Tuesday. The utter abandon with which he sought to attend to the best interests of all these many activities could not but produce a severe strain on his physical constitution.

"No word, however, would be complete without reference to his worth as a citizen and as a personal friend. He had led in so many worthy civic undertakings that much of Florence's life was identified with him. His human qualities were so genuine that many have said since his death, 'He was the best friend I had'.

"He will be missed in South Carolina. But South Carolina has reason to be grateful that he and his distinguished father were listed among her citizens. For they wrought a good work, and the influence of it will remain."

OUR NEW FRONT COVER

Since this is the Centennial Year of our Association it was thought wise to prepare a front cover which would not only be more attractive to the eye but would also be in keeping with the celebration of a one hundredth birthday. We hope that the efforts of the artist, based upon general suggestions which we made, will appeal to the members of the Association.

MEDICAL COLLEGE EXPANSION

In building a home, a man goes through three definite procedures. First he makes or has made a sketch of the proposed house, being sure that it will meet his needs, then he makes the necessary financial arrangements to care for the cost, and finally he supervises or contracts for the supervision of the actual building itself. These are logical steps for him to take and one would be thought a fool who did not adopt such a course of action.

When the Medical College found itself in need of expansion it adopted these same procedures which the head of family would use. First, the Dean and his special Advisory Committee made a detailed study of the situation and evolved a blue-print for action. This was presented to the Board of Trustees, and approved. A study by an out-of-state consultant showed the need for the program as outlined. The blue-print was next submitted to the South Carolina Medical Association which also approved the plan, following careful study by a special committee of seventeen.

The first step complete, the next objective was the securing of necessary financial support. A bill was introduced into the General Assembly calling for an appropriation from the state treasury to take care of the expense. The 1946 request was for \$1,500,000. In 1947 this request was raised to \$3,500,000 when it developed that the federal government would bear only one third and not two thirds of the cost, as had been anticipated. The bill was enacted into law last spring and recently was signed by Governor Thurmond. The second step was complete.

Just how soon the third procedure, that of actual building, will begin will depend upon the Board of Trustees but we feel sure that it will not be in the distant future.

As this Expansion Program has gradually developed, many have played a role. Physicians, legislators, and friends of the Medical School have all done their part. But as in any movement, there have been certain leaders and to these must go the most credit. Dean Kenneth Lynch who spearheaded the original study, and who worked so strenuously with the legislators to have the final bill approved. The Advisory Committee to the Dean who helped prepare the blue-print for expansion. Dr. T. A. Pitts, Chairman of the Board

of Trustees who worked so closely with Dean Lynch. The Board of Trustees of the Medical College. The Committee of Seventeen of the S. C. Medical Association who made a careful study of the program as presented and who did so much to acquaint the menibers of the Association and the public with the true facts in the case. The late Dr. James McLood, Chairman of the Committee of Seventeen, who, practically single-handed, was responsible for the passage of the original bill in 1946. To these, and to others whose names we do not have space to record, the medical profession of South Carolina owes a debt of gratitude. And not only the profession of today but the physicians of tomorrow who will reap the benefits of the enlarged Medical College as they pursue their courses of study. The public itself also owes these men much, for it is primarily for the benefit of the public that the Expansion Program has been put into action. With increased facilities, the college can not only retain its high rating but can improve its work—and in the ultimate, it is the average citizen in the state who will profit most from this.

COMMITTEE FOR YOUTH

At an open meeting of the Committee for Youth of South Carolina there were about a hundred people present. The speakers were introduced by Mrs. Kate B. Helms, who acted as chairman. The speakers were Dr. Ccorge D. Johnson, who represented the medical profession; Rev. Maxie Collins from Columbia, Assistant Director of South Carolina Federated Forces; Mrs. Eugene Spearman of Newberry, Executive Secretary of the South Carolina Division of the Southern Regional Council; Miss Lucia Murchison, Medical Social Work Consultant, Division of Maternal and Child Health, South Carolina Department of Health.

The idea behind this committee for the youth of South Carolina is to get information in each county about everything pertaining to youth. For example; from a doctor's standpoint, information such as how much money is spent for public health, how many patients are treated for syphillis, for tuberculosis, how many injections against communicable diseases are given, how many visiting nurse visits are made, and all the information pertaining to the health would come under this.

In other fields, how many days or weeks are spent in the school, how much is spent for the education of white and colored, how much home economics is taught and everything pertaining to the proper education of children. In other words, in every county, there will be set up a committee composed of a representative from each of the main divisions which make up the South Carolina Committee for Youth.

What we are going to do with this information remains to be seen, but the mere collecting of it will help inform the people about their county. For example, there is a book gotten out by the Russell Sage Foundation whose title is, "Your Community". This book has all the questions which should be asked about any different department. For example, it has in there questions which we should know about our medical department, how much is spent per person, how it's spent, how much is spent for inspection, and all that type thing. These are the questions which this committee should investigate, and when we get all the answers we will have a wealth of material. Then we can draw our conclusions and perhaps help influence our legislature to create laws which would

correct some of the more glaring mistakes. That is the purpose behind this committee. I think it is a very worthwhile thing, and I think it would be foolish for doctors not to participate. Doctors, as a rule, are in the doghouse because of their reluctance to take part in community affairs; and I think this is one opportunity where we can really step out and express ourselves on the health of our community. What we as doctors think should be corrected when we as doctors recommend. That is the purpose of this meeting.

Geo. D. Johnson

Special Meeting House of Delegates

Nov. 22, 1947 — Columbia, S. C.

The meeting was called to order by the President, Dr. Olin Chamberlain at 2:40 p.m. There were forty delegates present.

Dr. Chamberlain relinquished his chair to Dr. C. H. Blake, Vice President, while he, as Chairman of the Special Committee of Eighteen, presented his report.

Dr. Chamberlain outlined the method of creation of the special committee and told of its activities. He stated that the committee had secured the services of Dr. Harry Mustard of New York City, to make a special survey of the South Carolina State Board of Health during the month of August. Subsequently, the committee conferred with Governor Strom Thurmond and secured his ideas on the subject. Upon the basis of Dr. Mustard's report, Governor Thurmond's suggestions and its own study, the committee prepared its own report which Dr. Chamberlain then presented, giving each delegate a mimeographed copy (printed in full below).

Upon the recommendation of the secretary the members of the Committee of Eighteen who were present were allowed the privilege of the floor without the power to vote.

A resolution was presented by Dr. N. B. Heyward which was passed unanimously, thanking the committee for its work.

A motion was made by Dr. N. B. Heyward calling for a recommendation to the General Assembly that the State Board of Health in South Carolina as now constituted be left in statu quo. This motion was tabled with a vote of 29 to 6.

Motion made by Dr. Blake instructing the Executive Secretary to send a copy of Dr. Mustard's report to each member of the House of Delegates for study and that a subsequent meeting of the House of Delegates be held to consider the entire matter, was tabled 18 to 12.

Dr. J. D. Guess then introduced a resolution calling

for an adoption of the report of the Committee of Eighteen and with instructions to the President of the Association to do all within his power to have the necessary legislation introduced into the Assembly and to secure its enactment into law. This resolution was adopted by a vote of 34 to 4.

An amendment to the above resolution calling for the addition of a pharmacist to the membership of the State Board of Health as outlined in the report was tabled by a vote of 26 to 8.

There was full and free discussion during the two hours of the session with the following individuals participating: Drs. A. B. Preacher, N. B. Heyward, Robert Wilson, Adams Hayne, George D. Johnson, William Weston, Robert Durham, Hugh Smith, Wyman King, James Snyder, J. D. Guess, J. R. Kirkpatrick, J. K. Walsh, W. R. Wallace, J. H. Stokes, C. H. Blake, Frank Cain, Mr. M. L. Meadors, Drs. A. W. Browing, J. W. Chapman, I. H. Grimball, A. J. Josey, T. G. Goldsmith, J. P. Young, E. M. Dibble and J. P. Price.

REPORT AND RECOMMENDATIONS OF COMMITTEE OF 18

Paragraph 1: That the powers and duties now vested in the State Board of Health and in the Executive Committee of the State Board of Health be transferred to and vested in a State Board of Health of nine members to be appointed by the Governor as hereinafter set forth.

Paragraph 2: That the Governor shall appoint a State Board of Health made up of nine members, including five physicians, one dentist, and three other citizens of the state none of which three shall be a physician or dentist; that members of the Board shall be appointed in the categories set forth above as provided respectively in paragraphs 3, 4 and 5; that one physician be appointed for a term of one year, that one physician be appointed for a term of two years,

that one physician and one non-physician be appointed for a term of three years, that one physician and one non-physician be appointed for a term of four years, that one physician and one non-physician be appointed for a term of five years, and that one dentist be appointed for a term of five years, all such appointments to date from the first Friday in July 1948; that appointments subsequent to that date, except for the filling of unexpired terms, shall be for a period of five years and until a successor is appointed and qualified, and shall be made from the same categories respectively and in the same manner as those of the original appointees as above provided: that except members who have not served for as long as twenty-four months, no member may be appointed immediately to succeed himself or herself but may again be appointed a member of the Board after one year absence from such membership; that when a vacancy occurs, other than through expiration of term of appointment, the person appointed shall be qualified within the category in which the vacancy occurs and his or her term of office shall be the unexpired term of office of the person whom he or she shall succeed; and if this unexpired term shall be twenty-four months or more, the member who fills it shall be considered as having served the equivalent of a full term insofar as concerns eligibility for future appointment. Members of the State Board of Health shall be removable by and at the pleasure of the Governor for neglect of duty and other causes after a hearing by the Board, when at least five members of the Board certify to the Governor in writing that such a hearing has been held, and that they believe the charge or charges which they shall set forth, have been sustained and are sufficient cause for removal; provided: that no member shall be removed from the State Board of Health unless thirty days before the hearing of charges, he or she shall have been advised, in writing, of the specific charge or charges, against him or her and of the time and place for such hearing.

Paragraph 3: That Section 4997 of the Code of 1942, and such other sections as may be concerned, be so amended as to provide that the South Carolina Medical Association, at its first meeting after January first, 1948, shall elect nine members, to be recommended to the Governor on or before the next ensuing first Friday in June and the Governor shall appoint five of them, with others as set forth in paragraphs 2, 4 and 5, hereof, to constitute a State Board of Health, and that the Governor shall designate the term for which each of the five shall be appointed, as provided in paragraph 2 above; that at each annual meeting subsequent to the first one after the first of January, 1948, the South Carolina Medical Association and their successors, in their corporate capacity, shall elect three members, to be recommended to the Governor, on or before the next ensuing first Friday in June of each succeeding year, and the Governor shall appoint one of them to serve as a member of the State Board of Health for a period of five years.

Paragraph 4: That Section 5222 of the Code of

1942, and such other sections as may be concerned. be so amended as to provide that the South Carolina Dental Association, at its first meeting after Ianuary first, 1948, shall elect three members to be recommended to the Governor on or before the next ensuing first Friday in June and the Governor shall appoint one of them, with others as set forth in paragraphs 2, 3 and 5, to constitute a State Board of Health; and that at each fifth annual meeting subsequent to the first one after the first of January, 1948, the South Carolina Dental Association and their successors, in their corporate capacity, shall elect three members, to be recommended to the Governor, on or before the next ensuing first Friday of June, and the Governor shall appoint one of them to serve as a member of the State Board of Health for a period of five years.

Paragraph 5: That on or before the first Friday in July, 1948, the Governor shall appoint three citizens of the State, none of whom shall be a physician or dentist and who, with others as set forth in paragraphs 2, 3 and 4, shall constitute a State Board of Health, and that the Governor shall designate one of such citizens as appointed for a term of three years, as provided in paragraph 2; one for a term of four years, and one for a term of five years; that on or before the first Friday in July, 1951, the Governor shall appoint one such citizen, who shall not be a physician or dentist, to succeed the member originally appointed under this paragraph for a term of three years; that on or before the first Friday in July, 1952, the Governor shall appoint one such citizen to succeed the member originally appointed under this paragraph for a term of four years; that on or before the first Friday in July, 1953, the Governor shall appoint one such citizen to succeed the member originally appointed under this paragraph for a term of five years; that on or before the first Friday in July of each of the last three years in each succeeding five year period thereafter, dating from July, 1953, the Governor shall appoint one citizen of the state, who shall not be a physician or dentist, for a term of five years, to fill the term of the member in this category expiring in each of such years; and that when vacancies occur in this category of the membership of the State Board of Health, other than through expiration of term of appointment, the Governor shall, within his discretion, and in not less than thirty days, appoint a citizen of the State, who shall not be a physician or dentist, to fill the vacancy.

Paragraph 6: That if the said South Carolina Medical Association, or the South Carolina Dental Association, fail or refuse to make recommendation to the Governor as set forth respectively in paragraphs 3 and 4, then the Governor shall, within his discretion, appoint physician members of the Board, or dental member, as may be necessary.

Paragraph 7: That the State Board of Health, as provided for above, shall meet on the first Friday in July, 1948, shall proceed to organize and elect a chair-

man and secretary and is hereby empowered to adopt by-laws for the conduct of its business and to amend such by-laws. The Board shall meet once in each month and at other times when called by the Chairman or at the request of four members of the Board. It shall fully and completely record its actions and shall carefully preserve its records, and the State Health Officer is hereby authorized, within the limits of his budget, to utilize the services of such persons as are already employed by the State Board of Health as now constituted, to assist the Board in recording its actions and otherwise to assist the Board in the conduct of its business. The Board shall render an annual report to the Governor and the General Assembly, Members of the Board shall be entitled to compensation and to reimbursement of expenses as now provided.

Paragraph 8: That it shall be the duty of the State Health Officer, appointed and holding office as now

provided by law, to perform the duties and functions required of him under the existing laws of the State of South Carolina and to administer the activities of the State Board of Health as constituted under the terms of this Act and under the direction of the said State Board of Health, to whom the State Health Officer shall be at all times responsible, and it shall be the duty of the State Health Officer to see that all aets relating to the public health are enforced, subject to the direction and authority of the State Board of Health as herein constituted. He shall be responsible for enforcement of public health laws enacted in the future and for the enforcement of all regulations of the State Board of Health now existing or which the Board may in the future promulgate. He shall submit an annual report to the State Board of Health and the said Board shall transmit the same to the Governor along with, or incorporated as a part of, the annual report of said State Board of Health.

THE TEN POINT PROGRAM

M. L. MEADORS, EXECUTIVE DIRECTOR AND COUNSEL

THE STATE MOVES FORWARD

South Carolina is making progress in her efforts to deal with problems related to medical care. There is ample evidence of the fact, after a long period of lethargy in which the law-makers, doctors, and the public alike seemed entirely content with the conditions which had existed for many years. The General Assembly has taken definite steps toward expanding and increasing facilities which will mean real contributions toward the improvement of medical care in the State, and toward widening the base on which it shall be made available.

With the signing by Governor Thurmond of the Bill passed by the Legislature at its last session, providing for distribution of the ten million dollar surplus in the State Treasury, the development of the program of the Medical College of South Carolina is assured. Last year also, the Legislature passed an Act which became law promptly, providing the machinery to be used by the State in obtaining, and in the administration of the funds made available by Congress under the Hill-Burton Act.

It is gratifying to reeall that in both these matters the South Carolina Medical Association had an active part. The original appropriation of approximately one and a half million dollars, the amount then considered as necessary for the expansion of the Medical College, was put through the Legislature largely as the result of the work of the Committee of Seventeen, of which Dr. James MeLeod was the resourceful and energetic chairman. All of the influence of the Association was brought to bear with the result that the Bill was

passed at the same session of the Legislature in which the activities of the Committee of Seventeen had been exerted.

The set-up of the division of the State Board of Health which will administer South Carolina's participation in the hospital expansion program under the terms of the Hill-Burton Act, was the result of thought and effort on the part of a joint committee from the Association, the State Hospital Association and the State Board of Health. Except for the fact that the plan proposed by this joint committee would have provided for a separate commission, whereas the Legislature provided for a separate division within the State Board of Health, the Legislature adopted the plan proposed with only minor changes.

This year, following its agreement with the leadership of the Medical Affairs Committee of the Senate, the Association has made a study of the Board of Health and has submitted definite recommendations with respect thereto. These recommendations, approved and adopted by the House of Delegates, are proof, if proof were needed, of the ability and the desire of the medical profession in South Carolina to ecoperate with the law-makers and others outside of the profession in the general interest of the public.

Finally, the Association undertook during the last session to do something about the cults and unrecognized practitioners in the State. A determined effort was made to bring about an investigation of the practices of the Naturopaths and their Board of Examiners. For the benefit of the public, that effort should and will be renewed with determination in January. These are the sort of activities which the

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Proc. Soc. Exp. Biol. and Med., 1934, 32, 241 N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592.

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public has a right to expect from an organization as influential, as strong, as equipped for leadership in the affairs of the State as is the South Carolina Medical Association. It is through such efforts that the medical profession here and elsewhere can best convince the public of its genuine intentions in their behalf, and thereby postpone the evil day of medical care by government fiat.

NEW PUBLICATIONS

The month of November saw the addition of two new features in the publications released from the central offices of the Association.

On November 1st, or near that date, the first South Carolina Medical Association News Letter was mailed to all members of the Association. The second was published shortly after the first of December. It is hoped, through this medium, to supply the members of the Association throughout the State with bits of information of interest to them and related to the profession and its welfare, particularly in South Carolina, more rapidly than can be done through the pages of the Journal. Because of the circumstances under which the Journal must be prepared and printed, it is impossible to include in its columns information regarding current activities as quickly as might be desirable. It is hoped that through the News Letter, the members can be kept currently informed while the news is fresh, and the medium should serve as an excellent supplement to the services already available through the Journal.

The second feature added within the past month was the change in the content and concept of the Bulletin, which, with the issue last month, completed its first year. With the November number the name was changed from "Bulletin" to "Auxiliary Bulletin", and became the joint enterprise of the Association and the Woman's Auxiliary.

The Association and the Auxiliary are indebted to the late Dr. James McLeod for his vision and inspiration in instituting the Bulletin. It is published quarterly in mimeographed form from the Executive Offices of the Association in Florence, the first number having appeared in February 1947. The first three numbers were devoted to discussion of matters of interest to the profession, particularly along political and economic lines, with especial emphasis on the Wagner-Murray-Dingell Bills and the Blue Cross Plan. The original idea was, through this means, to reach the members of the Auxiliary with accurate and direct information which would enable them to participate actively in the public relations program of the Association. It is believed that the members of the Auxiliary, through their contacts and with the time at their disposal, are in better position to work effectively in connection with many of these projects than are the members of the Association themselves.

Some time ago it was suggested to the President

of the Auxiliary that the officers might wish to use the columns of the Bulletin as a medium for the release of information to their members. The suggestion was immediately approved by Mrs. Adcock, the President, and her Executive Committee. She cooperated in the venture from the beginning and most of the material contained in the November issue was supplied by Mrs. Adcock and other officers of the Auxiliary.

The ladies in many of the states have their individual publications. It may be that in South Carolina eventually they will wish to do the same. For the time being, the Bulletin in its present form however, can serve in the dual capacity of an organ for the Woman's Auxiliary and a means of informing its members, through the facilities of the offices of the Association, on current developments of interest to the medical profession.

BARUCH PROPOSES PLAN TO IMPROVE NATION'S HEALTH

The stature of Bernard M. Baruch is such that his public utterances on any subject awaken genuine interest on the part of the public and are attended with respect. That is generally true in South Carolina to an even greater extent than elsewhere. Despite his long residence in New York City and his position as a world figure, South Carolina still regards Mr. Baruch as, in a sense, peculiarly her own. He has kept his contact with the State in many ways, being a parttime resident at his beautiful home, Hobcaw Barony, on Winyah Bay across from Georgetown.

And when Mr. Baruch speaks of medicine, the problems of the profession, and the steps that should be taken to improve the nation's health, there is every reason why the medical profession of South Carolina should turn an ear and note what he has to say. His father was once President of the South Carolina Medical Association. The auditorium at the Medical College of South Carolina bears his name and is as the result of his generosity.

On November 19th, Mr. Baruch addressed approximately 600 physicians and hospital administrators at a dinner in New York, and according to New York Medicine, a publication of the Medical Society of the County of New York, "called on the medical profession to assume leadership in providing better health for the people of America".

There is a somewhat familiar ring about the expression used in referring to the address, in stating that it outlined a program "for improving medical and hospital services with provisions for government-financed protection for needy individuals". A good many of the points suggested in Mr. Baruch's address apparently were things that had been proposed in other quarters, and which perhaps may have been discussed from time to time. Their further projection

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by Mr. Baruch, a man of keenly analytical mind and excellent judgment, tends to entitle the subjects to further consideration by the profession and the thinking public. The article in New York Medicine continues:

"Pointing out that many doctors have been fighting a 'rear guard action' in providing medical care for all classes of the people, Mr. Baruch urged that the medical profession accede to the public demand for more and better medical services. He also stressed the need for cooperation with the government in obtaining government aid where necessary.

"Among the steps he specifically advocated were a survey to modernize medical education with greater emphasis on chronic and degenerative diseases, mental hygiene, and preventive medicine; fewer specialists and more general practitioners; the reorganization of medical practice with emphasis on group medicine and voluntary insurance; a new cabinet post for health, education, and social security; and the creation of a non-political watchdog committee to safeguard progress in medical care for veterans.

"Referring to the need for government aid in raising medical educational standards, Mr. Baruch said: 'If science and medicine ask the Government for aid, which even the conservative deems necessary, they must expect he who pays the fiddler will call the tune. This means the government will rightly insist on no discrimination in medical care because of race, color, or creed. It will rightly insist upon opportunity for all to enter the profession and advance on the sole basis of ability and character, without restrictions of race, color, creed, or sex. And, I hope, without fear of, or favor from, the State'.

"Mr. Baruch congratulated the physicians on their part in proving voluntary health insurance to be 'a sound practical way' of financing health services, Although, he said, they might in time serve the needs of the bulk of the people, he nevertheless voiced concern for 'that sizeable segment of society which does not earn enough to pay for voluntary insurance'.

"To provide for this group he recommended a program partially financed by the government, to be administered by a body of doctors and non-doctors to keep medical care as free from politics as possible. He suggested a form of health insurance with adequate safeguards for those who cannot pay for voluntary insurance. This can be achieved, he said, without involving 'what has been termed socialized medicine'."

Despite the fact that, as reported above, Mr. Baruch's program would provide for partial financing by government, it is indeed reassuring to the members of the profession to note his further remark in this connection. Mr. Baruch believes, according to the report of his ardress that

"The needs can be met, as in other fields, without the government taking over medicine, something I would fiercely oppose."

CULTIVATING RELATIONS WITH THE PUBLIC

It is always pleasing to note that some figure whose expressions are apt to be listened to with a bit more interest than our own, expresses the same thoughts that one has already expressed perhaps in different vein, not once but over and over again.

Dr. George F. Lull, Secretary and General Manager of the American Medical Association, made some comments on public relations in speaking to a luncheon audience at the 18th Annual Scientific Assembly, sponsored by several organizations interested in medicine and medical care in the District of Columbia, According to Dr. Lull, as reported in the November issue of the Medical Annals of the District of Columbia, "The best public relations consists of 80 per cent doing and 20 per cent publicity". The writer in the Annals, himself no mean authority on the subject, continues: "After all, the only purpose of a public relations program is to create good will and understanding. To attain this goal, the medical profession must earn it.

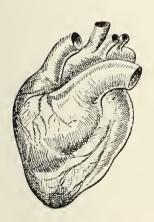
"There is no substitute for good medical care provided by competent and considerate physicians. This, of itself, will do more than anything else to instill confidence and create good will. Radio programs, speakers' bureaus and daily health articles are certainly worthwhile as health educational projects, and reflect credit on the profession. Equally important is the development of plans which will relieve the patient who is heavily burdened by costs of illness. There are, of course, many other ways of winning public support, but these are a few of the tangible evidences of the sincere interest in public welfare which deserve and receive public commendation."

AMERICA IN MEDICAL PROGRESS

Speaking before the 100th meeting of the Medical Society of Virginia in October of this year, Richard H. Shryock, Ph. D., Professor of History at the University of Pennsylvania, traced interestingly the progress of medicine during the past century, the changes in theories and principles on the treatment of disease, and the ever increasing part which research has played in the development of the science of medicine. He pointed out some of the reasons for the delay in many of the discoveries and their slow improvement, which, in the past few decades, have almost revolutionized some types of treatment. He showed that circumstances, economic and political, have had important bearing upon the development of medical research and practice.

Perhaps the most interesting and important of all the observations of Dr. Shryock, are those with respect to the part played by America in this development, and particularly the position which she now





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occupies. His paper, reported in full in the December issue of the Virginia Medical Monthly, pointed out how medical bacteriology led to antiseptic surgery, to a science of immunology, and eventually to an effective chemotherapy, also how it advanced disease identification and diagnosis to a most effective level. When it was possible to add to the criteria of symptoms and of lesions, the knowledge of the cause of these evidences of disease, rapid development of methods of treatment was a matter of course.

"When did American medicine join in this triumphant scientific procession?", the writer inquires. "Until about 1890 it largely followed in the rear. taking over its science from France until about 1860, and from Germany thereafter, Basically, as noted, the lag in American research can be ascribed to the fact that we were a practically-minded people concerned largely with the end-results of research. This was not because the United States was a 'new country', or because it lacked either the population or wealth to advance medical science had its people so desired. During the War Between the States, military surgeons amassed the greatest collection of pathologic data available anywhere in the world but did relatively little with it. Prestige in the American medical profession lay in successful practice, since this seemed practical and also led to income that accorded social standing. Research that had no bearing on cures, on the other hand, scemed impractical, brought no wealth, and so was tolerated rather than supported by either government or private philanthropists.

"In my opinion, the American people have not changed in this regard: we still seek that which is practical and we still cultivate efficiency. Do not let us under-estimate these attitudes, by the way, for there is much to be said for them. The very Europeans or Latin-Americans who ridicule our so-called 'materialism' are quite glad to take over our practical technology, or to seek the financial aid which is made possible only by our combination of commercialism and generosity. But the fact remains that our national attitudes did not encourage the support of pure research before 1890. How, then, explain the sudden appearance of first-class medical science in this country after that time?

"If Americans did not change, two other factors did. First, the discoveries of Pasteur's day revealed for the first time a type of basic research that did lead almost immediately to practical results. Immunizing vaccines and scrum therapy were very practical and Americans sought them avidly. Pasteur's work was barely under way before such Americans as Sternberg were making similar studies, within a few years certain of our fellow-countrymen were abreast or even ahead of European contemporaries. This can be seen in Theobald Smith's pioneer discovery of the insect vectors of certain infections. After 1900, American sanitary engineering—based now on bacteriology as well as on mathematics—became as good or better than that

of any other land. And we all know of the amazing progress of our native surgery during the Mayo era. Today, even the most basic cancer studies seem to be based here on the conviction that, after all, such research will really prove the quickest way to secure useful results.

"One other factor changed in this country, which also aided in placing American medical science in the van of world progress after 1914. This was simply the accumulation of great wealth, based on natural resources and on a superior technology. While some wealth was always necessary to support science, all the medical progress that has been noted rapidly made medical research—as well as medical practice—far more expensive than it had ever been before. The pathologist of 1850 needed as equipment only a table. washstand, a few chemicals and a surgical kit: while the clinician called only for some drugs, a lancet, and a stethoscope. Compare this with the elaborate and expensive equipment now required in medical laboratories or even in the wards. It was what the old astrologers would have called an 'angelic conjunction', that just when medical science became ever more costly, American institutions became ever more wealthy.'

Then follow the most important observations, with which Dr. Shryock concludes his paper.

"Of course, medical faculties always feel that their schools are short of funds; but compare their situation with that of many European institutions. The recent war has made this contrast more glaring. Next year, the medical school of Padua—one of the historic seats of early medical progress—will have just fifteen dollars available for the purchase or repair of microscopes. Ten or twenty students must use the same instrument.

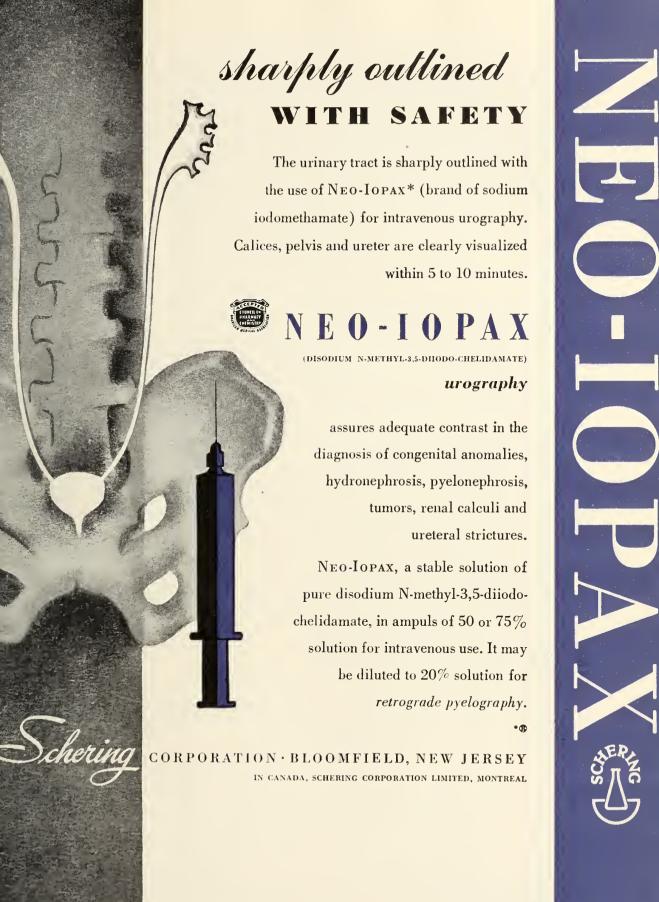
"Relatively, then, American medical science stands today in a position of unique advantage. It is our task, perhaps more than that of any other single nation, to carry the torch of medical discovery which has been handed on by great European predecessors. The realization of this situation should lead, not to national complacency, but to a determination to be worthy of this grave responsibility."

"I HAVE LOST A FRIEND"

Last week a man stepped out of this world to explore the multiverse and that adventure along the trail where the immortal souls of men travel.

In this life, he was unveeringly honest and frank with himself. Being of this sort, he was without pretense and the counterfeits characteristic of so many of those who live by expedients and stratagems. Yes, we shall miss his friendship. At this time of parting we pause and think.

How far we of the medical profession could go in meeting the challenges which confront us in this era of social unrest if each one would so order his ways



of life that at the time of demise all who have received care at our hands would say, "I have lost a friend".

Have we modern doctors in the zeal for better methods lost the human touch of friendship for those we serve? Meeting the financial obligations incident to medical care is often as much of a problem to the patient as recovery of health itself. If we turn an intellectual "blind spot" upon this phase of the patient's life, we may be fulfilling our duty as doctors, but we fall short of being "a friend".

The whole modern world needs something—more friendship perhaps. We're sure a little friendship added to the science of medicine would give it that soul and public good will which it had in the days of our horse-and-buggy grandfathers. — United Medical Bulletin, October 1947.

(Reprinted from New York State Journal of Medicine, December 1, 1947)

NEWS ITEMS

Dr. Keitt H. Smith of Greenville has been appointed by Governor Thurmond to the executive committee of the State Board of Health for a term ending in May 1949.

Dr. Robert B. Taft of Charleston, recently attended the annual meeting of the Radiological Society of North America in Boston. Dr. Taft presented a paper on "Radiation Treatment of Birthmarks".

Dr. W. Thomas Brookman, county publicity chairman, announces the addition of the following members to the Greenville County Medical Society: Dr. W. T. Martin, Dr. Cecil White, Dr. John W. Boling, Dr. W. A. Derrick and Dr. Peggy Fisher, all of Greenville, Dr. Andrew J. Causey, Greer, and Dr. Morgan Milford, Simpsonville.

Dr. Charles P. Corn of Greenville, recently attended the sixth annual meeting of the American Academy of Dermatology in Chicago.

At the annual meeting of the Southern Medical Association in Baltimore in November, Dr. W. Thomas Brockman of Greenville was named chairman of the section on proctology. Congratulations to Dr. Brockman are in order, for this is indeed a high honor.

Dr. Walter E. Bryant of Darlington has opened an office in Darlington for the general practice of medicine. For the past two years Dr. Bryant has been a member of the medical staff of the Johnson Memorial hospital in Hemingway.

Dr. Frank W. Chandler, Jr. of Sumter was married to Miss Louriene Mae Crawford of Kingstree on November 29th at the Kingstree Methodist Church. Dr. Crawford is a graduate of the Medical College of South Carolina and is at present interning at Louisville, Ky.

Dr. J. F. Wood has resigned from service with the government to enter general private practice with Dr. I. D. Durham in West Columbia. Dr. Wood served with the Veterans Administration for sixteen years, having been chief medical officer at the Veterans hospital in Fayetteville before resigning.

Dr. William P. McDaniel has begun the general practice of medicine in Walterboro, with offices at the EsDorn-Stokes Memorial Clinic.

Dr. Harry F. Wilson, Director, Division of Industrial Health, South Carolina Board of Health, was on active duty at the Oliver General Hospital, Augusta, Ga., during the first fifteen days in November. He is a Colonel in the Army Medical Corps Reserve and Commanding Officer of the 396th Evacuation Hospital which is a Reserve Unit.

Dr. A. M. Rubinowitz has recently been certified by the American Board of Dermatology and Syphilology. Dr. Rubinowitz is associated with Dr. J. R. Allison at 1724 Gervais St., Columbia.

Dr. William Russell Jones, Jr., recently joined the staff of Veterans Administration Hospital in Columbia.

Dr. and Mrs. C. Tucker Weston, Jr., announce the arrival of a baby girl on October 29th, at the Columbia Hospital.

Dr. and Mrs. David Wilson, Greenville, announce the birth of a daughter on November 9th.

Dr. David Reese, Greenville, has received a Bronze Star medal for exemplary conduct with an infantry regiment while serving in the campaign in Normandy.

500 ATTEND ANNUAL MEETING IN COLUMBIA

Approximately 500 doctors, dentists, nurses, sanitarians, health educators, technicians, and clerical workers registered at the annual meeting of the personnel of the State Board of Health and County Health Departments held in Columbia December 9 and 10.

The program of the two-day session, which opened at 10 o clock Tuesday morning with Dr. Ben F. Wyman, State Health Officer, presiding, included the invocation by the Rev. J. O. Kempson, Chaplain of the S. C. State Hospital; an address by Governor J. Strom Thurmond; remarks by Dr. Wyman; and, with Dr. H. Grady Callison, Director of the Division of Local Health Services, presiding, discussions of programs and future plans of various divisions by their directors. Speakers included Col. Wm. H. Moncrief. S. C. Sanatorium; Dr. Hilla Sheriff, Division of MCH; Dr. G. S. T. Peeples, Divisions of Crippled Children and Cancer Control; Dr. G. A. Bunch, Division of Dental Health; Mr. J. H. Stephens, Division of Sanitary Engineering; Dr. John M. Preston, Division of

Tuberculosis Control; Dr. G. E. McDaniel, Division of Preventable Diseases; Dr. R. W. Ball, Division of VD Control; and Dr. Harry F. Wilson, Divisions of Industrial Health and Laboratories.

During the afternoon, sectional meetings were held with leaders as follows: Health Directors, Dr. Leon Banov; Publie Health Nurses, Miss Ellie C. Nelson; Sanitarians, W. P. Boylston; Public Health Educators, W. Gordon Bunch; Clerical Workers, Mrs. Mary B. MacFarlane.

Tuesday evening from 7 to 12, the S. C. Association of Sanitarians gave an informal get-together party in the Rathskeller of the Jefferson Hotel. All who attended the meeting were cordially invited. Daneing and delicious refreshments were enjoyed.

The program Wednesday morning included reports on resolutions made at the sectional meetings; a talk on "South Carolina's Hospital Program" by Dr. C. L. Guyton, Director of the Hospital Division; elosing remarks by Dr. Wyman and Dr. Callison; and the motion picture "Making Good Food Better".

Governor Thurmond

In his address, Governor Thurmond strongly advocated a course in health education in South Carolina's schools comparable to the courses now offered in English, Latin and history.

Pointing to the need for more health education, the governor cited his own ignorance of essential health "Not until about three months ago," said, "did I learn how to brush my teeth properly." He commended the State Board of Health for its splendid dental health program in the elementary schools, but added that between 90 and 95 per cent of the ehildren in South Carolina are in need of dental attention.

South Carolina's health, he said, is "near the bottom and the State must have more doetors, dentists, and nurses. Statisties show that in this State there is only one doctor for every 1,659 persons, when the minimum should be one for every 1,000; only one dentist for every 5,500 persons, when the minimum should be one for every 2,000; and only one nurse for every 982 persons, when the national average is one for every 357. Fifteen counties in the State have no hospital facilities.

Deploring the fact that so many young men and women were rejected for military service because of physical defects, Governor Thurmond said that South Carolina ranked fifth highest in the nation in its venereal disease rate, and third highest in infant deaths.

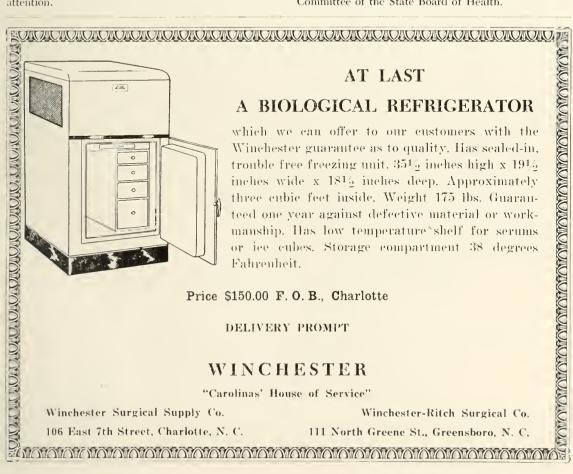
To remedy these unfortunate conditions, he said, "leaders of the State will have to realize the need for supporting health measures. No group ean do more than those in public health, and no other state offers a more fertile field for health work."

With reference to research work in health, Governor Thurmond said that he would like to see the federal government appropriate a large sum for that purpose. "If the leaders in Washington would put as much money into solving the cancer problem as they did to invent the atomic bomb, a cure for the disease would be found.

Dr. Wyman

Following the Governor's address, Dr. Wyman presented what he called a "new vision" of what ean be expected in the field of health service.

He explained the recommendations of the S. C. Medical Association for reorganizing the Executive Committee of the State Board of Health.



Referring to eounty health work, Dr. Wyman said that a present bill would make available to South Carolina \$1,600,000 for special county health programs, but that it would have to be matched with

\$1,200,000 in State and county funds.

He discussed the possibility of establishing or expanding laboratories in County Health Departments. He said that he expected more money from the federal government for the dental program, and that he be-lieved the legislature would appropriate \$150,000 next year for the control of cancer. He urged workers to "push" the immunization program, particularly for diptheria, and said he had asked for more money for the malaria control program. Each hospital in South Carolina, he said, will be given a supply of diphtheria anti-toxin for the convenience of doctors over the

In his closing remarks before the meeting adjourned on Wednesday, Dr. Wyman commended the clerical workers for having organized, and expressed the hope that advisory councils for the various programs of the State Board of Health would be appointed from the executive committees of the sectional groups—health officers, nurses, sanitarians, health educators and clerical workers. The recommendations made by these groups and adopted by the meeting as a whole, he said, would be presented as information to the Executive Committee of the State Board of Health.

Dr. Guyton

In his talk, Dr. Guyton explained South Carolina's program as provided for under terms of the Hill-Burton Act, which guarantees federal assistance to the State up to \$1,975,250 a year for five years for hospital and health center construction.

The money for use in constructing and equipping hospitals and health centers, Dr. Guyton said, will be available only to those communities who will match it two dollars to one. In order to receive the total five year allotment of \$9,881,250 it will be necessary for \$19,762,500 to be raised in South Carolina.

A hospital advisory council of 25 members was appointed in September, 1947 by Governor Thurmond to consult with the sole agency, the State Board of Health, as required by Public Law No. 725 (Hill-Bur-

ton Act).

Even though certain of the counties are too small to operate a hospital of a size economically feasible, Dr. Guyton said, the State Board of Health and the advisory council hopes for every county to receive its fair allocation of beds. Each county then may decide if it wishes to construct and operate its own facilities, or join with some other county or counties in providing for its hospital needs.

The state agency plans to offer assistance to any county in studying the type of hospital facilities it needs. Several of the rural areas will be encouraged to enlarge their hospital facilities so that they may become an intermediate area, serving as a district hospital for the territory in which each is located.

CORRESPONDENCE

December 12, 1947

Dr. Julian P. Price, Secretary South Carolina Medical Association 105 Cheves Street Florence, South Carolina

Dear Dr. Price:

The Veterans Administration is attempting to secure information pertaining to physicians in South Carolina who may be entitled to the rating of specialist. Certain standard qualifications for specialist rating have been set up by the Veterans Administration, and it is especially desired by the Branch Medical Director that an opportunity be given to the physicians in this

state to submit their applications for consideration.

The following standards for medical specialists performing Out-patient examination or treatment services on a fee basis under State-wide plans are promulgated by Veterans Administration Central Office Professional Services. These standards are for the guidance of Branch Section Chiefs in their recommendations to Branch Medical Directors for selection of specialists to function under State-wide contracts or agreements from lists of physicians proposed as specialists by State Medical Societies. Exceptional or meritorious cases of physicians who do not conform to the standards stated above will be referred for final decision to the Professional Standards Board in Central Office:

1. Those physicians who have been certified by the appropriate Specialty Board should advise this office of the Specialty Boards from which they

have received certification.

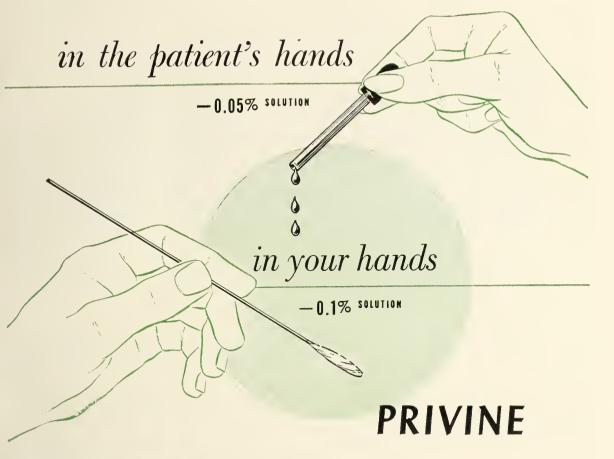
2. Specialists not possessing Specialty Board certificates-

- (a) At least four years experience in a given specialty, including recognized residency,
- (b) At least 50% of practice devoted to a given
- specialty, and
 (c) Recognized as specialists by the Medical Association or Society in the state in which he practices.

It will be very much appreciated if you could give us space in the next issue of your journal advising physicians who desire to be classed as specialists under the above criteria to submit their statements in the form of letters to the Chief Medieal Officer, Veterans Administration Regional Office, Fort Jackson, S. C. Your cooperation in this matter will be very much appreciated.

Very truly yours, D. B. WILLIAMS, M. D. Chief Medical Officer

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President: Mrs. D. F. Adcock, Columbia, S. C.

Publicity Secretary: Mrs. Kirby D. Shealy, Columbia, S. C.

A TRIBUTE

The Woman's Auxiliary mourns the passing of Dr. James McLeod. Lingering is the memory of a full and active life too soon ended. The rich rewards of achievement belong to this man who was a once skillful surgeon, loyal soldier, patriotic citizen leader and sympathetic friend to all who knew and loved him. Possessed of an indomitable will, a forthright approach to that which challenged his attention, Dr. McLeod's achievements are those of a realist. Yet with him he carried the spirit of a visionary. He could see that in the future to which many of us have been blind. He envisioned the passing of our democratic form of medical practice with its attendant evils of bureaucracy and socialism. Aware of the potential strength and influence of the Woman's Auxiliary, he was first among those in our state to challenge us to prepare for service to a profession dear to the hearts of each of us. His was a clarion call and with it he brought the encouragement and the financial support of our parent body that was needed. To him we are grateful for recognizing our potentialities, and should the need arise, let us not fall short of his dreams for us nor the opportunity to serve that great profession of which he was one.

Yes, we mourn with others the passing of a fine and good man in the early autumn of his days, and our hearts go out in deepest sympathy to his bereaved family, but within the inmost recesses of our minds we mourn the loss to our Auxiliary of a friend.

COASTAL AUXILIARY ORGANIZED

On November 13 a group of women met for a Dutch dinner at the Twnikling Star Tea Room in Walterboro for the purpose of organizing the Woman's Auxiliary to the Coastal Medical Society, composed of Colleton, Jasper, Dorchester, Berkley, and Beaufort Counties. Mrs. David F. Adcock and Mrs. Aldred F. Burnside of Columbia. president and first vice-president of the state Auxiliary, were there to help with the organization, also Mrs. Robert S. Gantt and Mrs. I. Ripon Wilson of Charleston, councillor for District 1 and first vice-president of the Charleston Auxiliary. Officers elected for the newly organized Auxiliary were Mrs. C. B. Woods, president, Mrs. J. W. Chapman, secretary, and Mrs. C. G. Chapman, treasurer, all of Walterboro.

MRS. ADCOCK HONOR GUEST AT MEMBERSHIP LUNCHEON IN SPARTANBURG

Mrs. David F. Adcock of Columbia, president of the Woman's Auxiliary to the South Carolina Medical Association, was honor guest at a membership luncheon of the Spartanburg Woman's Auxiliary on October 28 at the Peidmont Chib. Mrs. Adcock outlined plans for the year, emphasizing the national project of recruiting nurses for training in all hospitals. Mrs. John Watkins, president, presided over the luncheon. Mrs. W. H. Folk gave the invocation. Mrs. L. E. Madden of Columbia, state public relations chairman, was

recognized as a guest. Those attending were Mrs. P. M. Temples, Mrs. Furman Wallace, Mrs. J. A. Workman, Mrs. C. B. Hanna, Mrs. W. T. Hendrix, Mrs. Pearson, Mrs. Woodruff, and Mrs. McCord of Woodruff, Mrs. Dennis Hill, Mrs. Leon Poole, Mrs. William H. Folk, Mrs. Earle Poole, Mrs. W. C. Herbert, Jr., Mrs. George Price, Jr., Mrs. J. C. Josey, Mrs. G. D. Johnson, Mrs. Charles Poole, Mrs. E. M. Colvin, Mrs. W. H. Coopman, Mrs. Jesse O. Wilson, Mrs. Edward Law, Mrs. D. C. Alford, Mrs. J. W. Allen, Mrs. B. L. Allen, Mrs. A. K. Tennples, Mrs. William Cochran, Mrs. John O. Watkins, Mrs. John Flemming, Mrs. Ed Cochran, Mrs. Clough Wallace, Mrs. Robert Leonard, Mrs. Sam Black, Jr., Mrs. Robert Crow, Mrs. J. D. Nelson, Mrs. W. P. Coan, Mrs. W. A. Wallace, Mrs. Claude Finney, Mrs. Ruskin Anderson, Mrs. J. T. Carter, Mrs. Lesesne Smith, Mrs. Jeanes and Mrs. Flynn of Lyman, and Mrs. John Shirley.

The November meeting of the York County Medical Auxiliary took the form of a Dutch luncheon held in the private dining room of the Andrew Jackson Hotel.

Covers were laid for 21 guests and visitors at a long table decorated in yellow and gold. The place of each guest was marked with a minature corsage of yellow and gold.

Mrs. Roderick Macdonald, president, was in the chair and Mrs. Frank Gaston, program chairman, presented an interesting panel discussion on medical bills now pending in Congress. Taking part were Mrs. Rufus Bratton who talked of the Blue Cross plan, Mrs. J. L. Bundy who discussed the Wagner-Murray-Dingle Bill and Mrs. W. W. Fennell, Jr., whose subject was the Taft Bill.

During the business session reports were heard from Mrs. Frank Gaston, treasurer, Mrs. Gaston Quantz, secretary, and Mrs. Frank Strait, vice-president.

Mrs. Strait reported that the York County Medical Auxiliary last year received the Jane Todd Crawford Memorial Bed and will present it to the York County Hospital.

Plans were also made for assisting the nurses at York County Hospital with their annual Chirstmas dance.

Special guests were Mrs. W. C. Whitesides and Mrs. E. E. Strong both of York.

Mrs. Charles Mims was hostess to a most interesting and important meeting of the Auxiliary to the Greenville County Medical Society at her home on Hillcrest Drive when Mrs. Paul H. Leonard of Columbia, state director of the Field Army of the American Cancer Society, and R. W. Hudgens, national head, were speakers on the work of the organization.

Mrs. J. W. McLean, president of the Auxiliary, was in the chair, and assisting Mrs. Mims in entertaining were Mrs. M. Nachman and Mrs. H. M. Whitworth, Ir.

A large number of members were present for the meeting.

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Number 2

Phlebothrombosis

Occurring in Absence of Trauma or Bed Rest George T. McCutchen, M. D. William C. Cantey, M. D. Columbia, S. C.

The subject of clotting within the deep veins of the legs has become a very live one during the past few years. We have even gone so far as to coin the word Phlebothrombosis to describe this condition and to distinguish this syndrome from Thrombophlebitis (phlegmasia alba dolens or "milk leg"). The writings of Allen, Ochsner & DeBakey have particularly emphasized the prevalence of this condition and have outlined the necessity for interruption of the deep venous system to prevent the serious embolic phenomena which result from dislodgement of clot within the vein.

In an effort to prevent the occurence of phlebothrombosis in patients confined to bed many systems of exercise have been devised. Active and passive motion of the legs, bicycle riding and now "Early Ambulation"-to mention only a few-have all been tried. The regime outlined by Frykholm in 1941 appeals to us as the most rational of these devices but we would like to call attention to the fact that there are yet some imponderable factors which relate to this condition. The cases which form the basis for this report fall into this category. They are cases in which PHLEBOTHROMBOSIS OCCURRED IN INDIVID-UALS WHO HAD NOT BEEN CONFINED TO BED AND HAD NOT SUFFERED TRAUMA TO THEIR EXTREMITIES. In two of the cases chest manifestations characteristic of pulmonary embolism were the first indication of illness and the presence of phlebothrombosis was discovered during the course of examination.

-Report of Cases-

Case I

Mr. F. M.—Age 48—Providence Hospital #3268, presented himself to Dr. J. H. Gibbes on the 3rd of December 1946 complaining of a severe attack of pain in right chest accompanied by cough and a small amount of blood flecked sputum. He had no complaints referable to any other part of the body .X-ray

of chest (Fig. I) was made on the same day and confirmed the clinical finding of pneumonic infiltration in the right lung with an area of pleural reaction. Further examination revealed the presence of tenderness and swelling of the left calf with a positive Homan's sign. He revealed at this stage that he had noted pain in this leg for 3 to 4 days prior to the development of his chest symptoms. The chest symptoms and the findings on chest x-ray were thoroughly consistent with a diagnosis of pulmonary embolism. Ligation of the superficial femoral vein in the left leg was performed promptly. The pain and tenderness in the leg subsided and there has been little residual.



Figure I Shows infiltration in right lung near periphery,

No confinement to bed or trauma had preceded the onset of chest or extremity symptoms.

Case II

Mr. H. L-age 52-Columbia Hospital #14454. noted pain and swelling in the right leg August 29th, 1946. He was ambulatory at the time and had not been confined to bed prior to the onset of these symptoms. He continuted ambulatory until September 17th, 1946 when he noted sudden severe pain in the lower left chest accompanied by cough and the expectoration of sputum slightly tinged with blood. He consulted Dr. Watson Talbert who discovered a pneumonic infiltration in the left chest and confirmed these findings and the presence of pleural reaction by x-ray (Fig. II) on the same day. By this time the entire right leg was edematous and tenderness was present on the inner aspect of the thigh as well as in the calf. He was treated by bed rest and chemotherapy with subsidence of his chest symptoms within about 5 days. He was seen in consultation referable to the condition of his leg at about this time. Swelling was still present but pain and tenderness were absent. A venogram (Fig. III) was performed on September 27th, 1946 which revealed complete blockage of the deep venous circulation of the right leg. The clotting process in the vein was considered inactive because of the clinical picture at this time, so that surgical interruption was not performed. During convalescence he was urged to keep his activity below the "edema level". He now has little or no evidence of residual in the involved lower extremity.

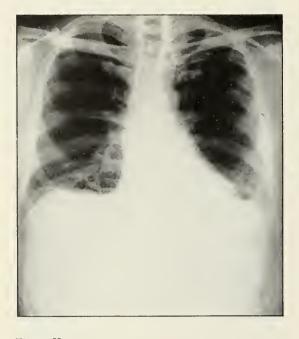


Figure II

Shows infiltration of left lung base with obliteration of costophrenic angle.



Figure III

Venogram shows complete absence of diodrast in elements of the deep venous circulation. The great saphenous is visible throughout its extent. These findings represent complete blockage of the deep circulation.

Case III

Mr. A. H. H.—age 62—Columbia Hospital #18443, noted pain and swelling in the calf of the left leg on December 2nd, 1946. He was squatting down at the time the pain was noted but there was no direct trauma to the leg. Pain and swelling increased to include the thigh. Lumbar sympathetic blocks done

elsewhere were of no avail in reducing the degree of pain and swelling. Bed rest did not produce a noticeable reduction in swelling. Patient was seen in consultation with Dr. J. H. Gibbes on February 11th, 1947 for consideration of ligation of the vein of the left lower extremity. The process was considered as relatively inactive at this time but since swelling continued in spite of bed rest it was considered advisable to ligate the vein. The common iliac was selected as

Figure IV

Venogram shows complete absence of diodrast in the deep circulation. The superficial circulation. (great saphenous) is well outlined. These findings represent complete blockage of the deep circulation. the site of ligation because of the high level of edema and the character of the venogram (Fig. IV). Ligation of the common iliac vein was performed on February 17th, 1947. Clot was encountered at the point of



Figure V

Venogram shows filling of the deep circulation. Small elements of the superficial circulation are visible in the region of the calf. The anterior and posterior tibial veins are dilated and more than normally tortuous. The presence of elements of the superficial circulation and distention of the tibial veins represent blockage. In this case the blockage was partial and resulted in "puddling" of blood in the deep veins of the calf with its resultant train of symptoms,

ligation. The vein was not severed. Following operation edema of the leg rapidly subsided. He was discharged from the hospital February 26th, 1947 with instructions as to gradual resumption of activity.

The condition of this man was complicated by the presence of diabetes and manifest selerosis of the arteries of his lower extremities. There were also decreased oscillometric excursions in the left lower extremity. However, his only confinement to bed prior to onset of symptoms was for a period of 2 days in October for what was described as atypical pneumonia.

Case IV

Miss I. M. G.-age 52-Columbia Hospital Case #18592, noted pain and swelling in the calf of the right leg in February, 1946. She had not been confined to bed and had suffered no trauma prior to the onset of these symptoms. Acute pain subsided within a few days but soreness in the calf with swelling of the leg were noted on standing. She had suffered these symptoms for a period of a year when she was seen in consultation with Dr. A. I. Josey. A venogram was performed February 17th, 1947 (Fig. V) which revealed dilatation of elements of the anterior and posterior tibial veins with narrowing of the popliteal portion of the deep vein. On the basis of these findings a ligation of the superficial femoral vein was done to prevent "puddling". She has been relieved of discomfort in this leg and residual edema is minimal. This ease is believed to be one who suffered occlusion of the deep venous system a year ago. The occlusion was incomplete at the time or considerable recanalization of the vein had occurred to produce the findings on venography.

-Discussion-

Spontaneous, unprovoked clotting in the deep veins of the lower extremities producing clinical manifestations is an extremely unusual occurrence. A report in the literature of such occurrence in otherwise healthy persons has not come to our attention. We would like to emphasize the necessity for careful examination of the legs as possible sources of emboli in patients with chest conditions whose symptoms might suggest an embolic background. The fact that four cases of "spontaneous" phlebothrombosis have been en-

countered in a short period of time suggests that such cases have gone unrecognized in the past or that there is a notable increase in their incidence.

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The Lame Back With or Without Sciatica

By Austin T. Moore, M. D. And Weston C. Соок, M. D. Columbia, South Carolina

The principal part of this presentation is a color motion picture film that will be shown. The film demonstrates the prop graft operation we have devised for surgical fusion of the unstable spine and it shows the removal of an unusually large herniated nucleus pulposus. The preliminary remarks will briefly outline the conservative and operative treatment of the lame back problem—with and without sciatic radiating pain.

There are two thoughts in particular that should be stressed. First, the problem is principally an orthopaedic one and no case should be treated conservatively or radically without a careful orthopaedic analysis and evaluation.

Second, while it is true that a thorough period of conservative treatment and observation should always be tried, conservative treatment is not conservative if it means that an individual who could be relieved by surgery is condemned to a life of semi-invalidism.

Since 1934, when Mixter and Barr described their revolutionary concept of "Rupture of the Intervertebral Disk", there has been a tidal wave of professional reports and opinions—with various methods advocated for relief of this problem. The pendulum rapidly swung from the ultraconservative orthopaedic recommendations of rest, corrective exercises, supports, etc. to the extremely radical advice of some neurosurgeons that every patient with a low back pain that was aggravated by coughing or sneezing should have his ruptured disk removed. Many of the results were disastrous. With experience we are approaching a middle ground and a clearer understanding.

The senior author's experience began in 1936. Since then he has studied his own cases and those of others with increasing interest. Recently at a meeting in Chicago an exhibit of this work was presented with a critical statistical analysis. The charts on exhibit here also show the result of this study.

There are many causes for low back pain. Among them may be mentioned nutritional disorders, emotional stress, neurosis, hysteria, muscle imbalance, chronic strain, focal infections, constitutional diseases, kidney, pelvie or rectal pathology, myositis, fascitis, neuritis, arthritis, tumors of the spine or spinal cords, etc. Many patients have consulted chiropractors and other charlatans, after failing to obtain relief following an inadequate study.

When it has been determined by appropriate tests that there is definite evidence of instability of the spine

(Read at annual session, S. C. Medical Association)

or nerve root pressure, appropriate treatment should be instituted as soon as possible. If nerve root pressure is allowed to exist for six months, or longer, the changes may be irreversible. Pain may be relieved but reflex changes sensory disturbances and loss of motor function with muscle atrophy may continue indefinitely.

It is true that all cases should have the benefit of a thorough period of conservative management. It is also true that unnecessary procrastination may convert an emotionally unstable individual into a confirmed neurotic who cannot be relieved by any measures. It is very difficult to determine when this stage has been reached. We have observed a considerable number of cases classified as neurotics that did obtain relief following appropriate treatment.

A careful orthopaedic and neurological examination will require at least one hours time at the first consultation. In addition there must be special tests, x-ray studies and consultation with perhaps a number of physicians in specialized fields of medicine. The majority of patients can be satisfactorily managed without hospitalization by correcting their constitutional ailments and prescribing postural corrective exercises, local supports and physical therapy.

Hospitalization for complete rest in the relaxed position with knees and shoulders elevated, leg traction, manipulation with or without anesthesia, forced flexion exercises, adequate sedation during acute attacks, local novocaine injections, special vitamins and medicinal therapy, instruction in physical education, a plaster jacket or rigid brace support is needed in more advanced cases.

The psychological attitude is a major part of the problem in many cases. Especially is this true when compensation is involved. A satisfactory financial settlement, with social or vocational readjustment, is often necessary. All of these are part of the surgeon's responsibility. Malingerers and neurotics are usually the product of inadequate professional care.

There remains a fairly large percentage of patients who are not relieved by a full measure of conscrvative treatment. Patients of middle age or beyond desire to be made comfortable for their later years. They are likely to become neurotics if not relieved. This is especially true if they have suffered more or less discomfort and have had recurrent attacks of acute episodes of pain for years.

Younger individuals have their lives ahead of them. If their handicap is of such a nature that it is necessary to alter their vocation or profession it is a serious disability. A back weakness in young adults usually becomes worse as age advances. These patients have pain in the low back that radiates into one or both lower extremities. The spine is held rigid with muscle spasm. The body may list to one side and they may not be able to assume the erect position during an acute attack. On examination there is tenderness over the lumbosacral region, the tendo-achilles jerk is lost and there is a zone of hypalgesia long the pattern of of the fifth lumbar or first sacral dermatome, X-rays may demonstrate a narrowed intervertebral joint space, telescoped apophyseal joints and other evidence of mechanical weakness of the lumbosacral region. Such patients have nerve root irritation or mechanical nerve root compression. By appropriate tests the differential diagnosis can usually be made between a herniated nucleus pulposus and mechanical pressure due to an unstable spine. If by surgery and by no other means, the young man can be made normal and the older man comfortable, operation is indicated and it is a conservative and not a radical procedure. Conversely, conservative treatment that seriously alters one's life is very radical in so far as the patient is concerned.

In most cases an exaggerated lordosis (sway back) is primarily responsible for the development of symptoms. The back weakness predisposes to a rupture of the intervertebral disc with herniation of the nucleus pulposus. Operation to remove the disc does not cure the back weakness and therefore in so many cases does not relieve the patient of pain. A recent survey of a large number of insurance cases operated on in many well-known clinics throughout America reveals that sixty percent and more had postoperative pain and disability after removal of the ruptured disc. This finding coincides with our study that sixty percent of the patients with typical disc symptoms do not have ruptured discs.

The explanation for this is simply that as the intervertebral space narrows and the spine goes into more lordosis at the lumbosacral region the nerve root is compressed at the intervertebral foramen. For relief the spine must be blocked open or propped with a bone graft that holds it in this position and permanently protects the nerve root from any further pressure.

This is the type of operation we have devised. With time and increased experience the technic has been improved. We have found that the best results depend on the best operation. It is also necessary to protect the patient by bed rest, a cast or a brace for an adequate time after operation until union is firm and sufficiently strong to bear the stress and strain of ordinary activity. There are individual problems in every case. We now obtain the donor bone from the crest of the ilium instead of the harder cortical bone from the tibia. This bone is revascularized sooner; union is earlier and more certain. A number of bone blocks are mortised into position with the spine acutely flexed so that they cannot slip out of place. This successfully immobilizes the region and fulfills one of the basic requirements in bone grafting and fracture therapy.

There are bony defects in the spine of some patients that make it impossible to secure complete immobilization. These patients must remain in bed for a longer period. Some patients may have a ruptured disc with apparently a normal bony architecture of the spine. In such cases after removing the protruded mass of nuclear tissue the patient may be up in a few days and leave the hospital in approximately a fortnight.

We have found that most patients have an unstable spine with some mechanical weakness and for permanent protection most cases that need operation should be fused. Fusion of the lumbosacral region is difficult and requires skill and precision for its success. Fusion should involve only one segment if possible. There is no noticeable stiffness of the spine following this type of operation. The nearer to perfection is the technic of the operation the nearer to perfection is the end-result.

With an experience of ten years and over 300 operations dealing with this problem, we find that there are still many questions unanswered. Time and much more study is necessary before final end-results can be determined. The results are increasingly more satisfactory. We hope that we are nearer to the solution of the lame back and ruptured disc problem.

SUMMARY

- 1. The unstable spine with or without ruptured disc is an orthopaedic problem that requires intensive study for its proper evaluation.
- 2. Most cases can and should be treated conservatively. Some require operation.
- 3. Operation is the most conservative type of treatment in certain cases.
- Excellent results from surgery are difficult. They
 require excellent surgical judgment, an excellent
 operation and excellent follow-up care.
- 5. Mental, physical and vocational rehabilitation is part of the surgeon's responsibility.

Rabies

J. C. Moore, M. D. Charleston, S. C.

INTRODUCTION

Rabies is an acute infectious disease caused by a filterable virus, transmitted by the bite of an infected animal and characterized by a condition of increased nervous system excitement followed by paralysis.

During recent years we have seen the importance of a clear understanding of the problem of rabies in medical science. With the ever increasing tendency toward massing of the population and with our almost sudden economic upheavel over the past several years we have seen a definite increase in this public disease. With our public health records together with the frequent occurance as seen in our daily papers, surely we can not deny that this problem is far from being

We must get away from the attitude that this public disease eoneerns only those who are interested in preventive public medicine. Every physician should be familiar with this disease, and together with public education should hold this disease to a minimum.

HISTORY

Rabies (L. rabere, to rage) has to its credit a long and interesting history going back to ancient times. Aristotle recognized the disease and believed that the bite of the rabid dog was largely responsible for its transmission. Celsus in the first century A. D. called the disease in man hydrophobia because of the marked symptom of fear of water shown by man. It is recorded that sound of water being poured or splashed would hring on convulsions in man. This characteristic has not been noted in any other animal. Celsus suggested cauterization of the wound, a treatment which was not surpassed until the time of Pasteur. Later Galen recommended extensive excision of the wound.

Probably the earliest modern work began around 1575 by several Italian physicians. Many methods of treatment were tried during this period including bleeding, mercury, curare, and electricity. Here, as in many other fields of early medicine we pass through the periods of uncertainty, substitution, and treatments which we realize today to be erroneous.

Rabies first began in isolated areas, later spreading throughout the world in epidemic proportions. It was occasionally found in herbivorous animals, more rarely in birds and swine, but among the carnivorous animals epidemic ratios were evident.

In 1683 Martain Lister described a case of a man being bitten by a mad dog. Six weeks after the wound

(Presented as his senior thesis, this paper by Dr. Moore was runner up for the Ravenel Award at the Medical College of South Carolina last spring.)

had healed the patient began to complain of pain in the back and stomach, while later he was unable to swallow liquids. Treatment at this time consisted of bleeding and using plaster and theriaca. Theriaca, one of the popular medicines of the day, was considered to be an antidote to the poison of wild animals. It contained about sixty substances and was palverized in honey. This patient later assumed the position of a dog and lapped liquids. Convulsions and death soon followed.

Lister reported other cases, one concerning two boys handling a dog wounded by a mad dog. Though the dog handled did not develop rabies, the boys developed what was believed to be rabies six months later. Roger Howman in 1684, at Norwich, England, described a case resulting from a bite of a mad fox. Treatment consisted of roots and crab claws boiled in milk.

In this same period the royal physicians prescribed roasted garlic and onions with honey made into an ointment. Later boiled liver from a mad dog, bathing in salt water every day, and powdered oyster shells were also used.

With the beginning of the 19th century the achievements of Pasteur began to get public notice. Alongside Pasteur's work other infallible cures continued to be attempted. As times changed so did the method of scientific study. Clinical observation and experimental proof were gradually substituted for the old treatments and superstitutions.

It was in the years 1800 to 1801 that the contagiousness of rabies was proven together with the realization of the importance of mucous and saliva. Pasteur in 1880 foresaw the possibility of vaccinating dogs against rabies. He showed that the causative agent in rabies had special affinity for the central nervous system. A large part of Pasteur's early work was with rabbits because of the so called "dumb" reaction obtained as compared to the "rageing" reactions seen so commonly in dogs. Pasteur also showed that the agent responsible for rabies could be weakened by drying and by using different strains this weakened agent could be used as a vaccine.

During this period the duration of the disease was from one to eight days and recovery rare. In view of our present day knowledge the diagnosis is questionable in those early studies which mentioned rare recoveries in humans. There were numerous reports of suicide in individuals who developed signs of rabies.

Remlinger and Riffat Bey in 1913 demonstrated the filterability of the virus. Negri in 1903 showed definite inclusion bodies in the central nervous system.

The Health Organization of the League of Nations, founded after the first world war, was responsible for collecting valuable data concerning the disease and results of treatment.

ETIOLOGY

Since it was first shown in 1913 that the etiological agent was a filterable virus, numerous investigators have arrived at similar conclusions, so at the present time there are two types of virus recognized. (1) "Street" virus which is found occuring naturally in animals. It has the characteristics of long incubation period, high infectivity following perpherial inoculation, production clinically of either the manic "furious" or the paralytic "dumb" disease and presence of Negric bodies in the nerve cells are usually noted. (2) "Fixed" virus is used in preparation of antirabic vaccine. The characteristics of this type is just about opposite those of the street virus, having short inoculation period of five to eight days, low susceptability in animals, development of only paralytic types of disease and Negric bodies being seldom found.

Fixed virus is produced by serial passage of street virus through animals chiefly rabbit or mouse. The number of passages vary greatly with different strains, two to fifty being upper and lower limits. Some very virulent strains, known as reinforced strains, become fixed after relatively few passages, while strains of very low virulence are resistent to fixation even after prolonged passage.

Galloway and Elford in 1936 reported the size of the fixed virus between 100-150 milli micro. These men used the technic of collodion membrane ultra filteration. Poei, 1938, estimated the size of the street virus between 160-240 milli micro.

Rabies virus has never been grown in a test tube. This virus has characteristics of being very filterable under special conditions of dilution or pressure and is readily thrown down in suspension by centrifuging. It is rapidly destroyed by sunlight and boiling kills it instantly, with heat at 60 degrees C. killing in five minutes. Formalin also quickly destroys it and which is often used in preparation of vaccines.

EPIDEMIOLOGY

Rabies is an acute infectious disease of mammals caused by a virus which has special affinity for the central nervous system. It is communicated by the bite of an infected animal or by contact of a wound with the saliva of such an animal.

Rabies is a cosmopolitan disease which has occurred in all parts of the world except Australia and Hawaii. Up until the war years several countries were free of the disease, including Great Britian, Denmark, Sweden, Norway, and Switzerland. Birmingham, Alabama has often been considered by many as the "rabies capital" of North America and possibly of the entire world. This title is largely the result of an epidemic lasting seventeen years, during which forty-

eight deaths were recorded due directly to rabies.

The incubation period of rabies varies greatly. The shortest reported being ten days, the longest being two years, with two months generally accepted as an average. This great variation is probably due to the fact that the virus reaches the central nervous system by the way of the peripherial nerves and thus the location of the wound will determine the distance. Shorter incubation period occurs, the nearer the wound is to the brain.

Rabies is essentially a disease of mammals, however, all warm blooded animals may become infected. The most common animal vector being the dog comprising eighty-five percent of the cases, wolves and cattle eight percent and cats about five percent. It can easily be seen why dogs tend to spread the disease more so than any other animal, because of the extent to which they roam the streets. The diagnosis in cats is often missed because they usually develop a paralytic form which goes unrecognized. However, cats do occasionally develop a furious type and are very dangerous. Horses, goats, and pigs make up a small percentage of the cases.

An important feature in the dangerous spread of rabies by dogs is that the sputum of a dog may be highly virulent for fifteen days before he shows any symptoms. During this period spread is highly probable especially if saliva comes in contact with an open scratch or hangnail on the human. Dogs seldom bite during this stage.

There is only one case reported in which it was certain that infection was transmitted from one human to another.

The question of the natural carrier often arises and to the present time remains unsettled. Dogs are considered by many, others consider rats and skunks. One epidemic in Trinidad in 1930 was traced to vampire bats, however it is extremely unlikely that this be the natural carrier.

The U. S. Death Registration covering a seven year period showed six out of every ten cases to be in children under fifteen years of age and seven out of ten were boys. These represent individuals who are more likely to be exposed.

In the human the nearer the bite to the brain the more likelihood of the disease to develop. An average of ten percent of those exposed and untreated persons develop rabies. This figure is greatly increased in cases of multiple deep lacerations, especially near the head.

SYMPTOMS

Rabies is a serious disease in man, being invariably fatal in two to eight days after onset. The mortality rate in humans is now believed to be 100 percent, however it is possible to prevent development of rabies in ninety-five percent of the cases by prophylactic vaccine.

From a public health standpoint, the dog is by far the more important animal transmitter and the recognization of this disease in dogs cannot be underestimated. In dogs as in humans there are two general types of symptoms—(1) furious (2) dumb. In the early stage of the furious type the dog may be simply less affectionate and his appetite sub-normal. Later he will bite at objects and especially at other dogs. Several days after onset, spasmodic seizures begin with characteristic low howl followed by low pitched barks. Between attacks he may appear almost normal. He may or may not "froth" at the mouth. Paralysis sets in and death occurs in four to eight days after onset. In the dumb type in dogs the first symptom is often a paralysis of the lower jaw, giving the appearance of a bone in his mouth. This type does not bite but his saliva is very virulent. Gradually, the rest of the body becomes paralyzed.

Symptoms of furious rabies in the human are not characteristic early. There may be indefinite nervous symptoms, constriction of the throat or difficulty in walking. Temperature slightly elevated to 100 degrees to 102 degrees F. Fear of water develops early due to painful spasm from attempt to swallow. Throat spasms may be caused by drafts of air (aerophobia) or loud noises (hyperacusis). Attacks increase up to the second day. There may be hallucinations or even mania. There is no desire or attempt to injure others. Vomiting is common and voice may be hoarse, resembling howling. Eyes show photophobia, nystagmus or even strabismus. Patient may die suddenly at any time, but usually after four to five days passes into paralytic stage. The lower jaw drops, ropy saliva, temperature just before death usually goes to 107° to 111° F. In this paralytic stage the extremities become heavy and numb, with sudden onset of ataxia following. Progressive paralysis results in death due usually to respiratory failure. Duration of the disease is two to eight days.

This paralysis is believed to be the result of the direct actions of the rabies virus, which causes degeneration of the nerve fibers. Before this degeneration occurs there may be pain at the site of wound because of changes in spinal cord corresponding to the segment receiving the nerve from the site of inoculation.

Paralytic rabies may often produce complicating and varied pictures making diagnosis very difficult. Howman, in 1684, probably reported the first case of predominant form. His report dealt with a man who became paralyzed in only the right arm six weeks after being bitten by a rabid fox.

Gamalia, in 1887, collected twenty cases of rabies in which paralysis was the outstanding feature. However, he brought the point up in his paper that in certain cases, even if the predominant symptoms are paralytic, that same patients may have, also, symptoms of the furious type. These cases developed paralytic form first but later developed difficulty in swallowing, pharyngeal spasm, hydrophobia and excessive salivation.

Renlinger, in 1906, called attention to the fact that rabies virus is one of the pathogenic agents which could cause acute ascending paralysis. He reported that rabies may occur as predominantly paralytic disease "in which the paralysis may begin in the lower extremities, rise to the bladder and rectum, spread to the upper limbs and then to the bulbar nerves."

Von Gehuchter, in 1907, reported one case of rabies in a 47 year old man who had been bitten on the chin by a rabid dog. This man showed a flaccid paralysis which began in the left arm, spread to the right arm, trunk and lower extremities. There were no sensory changes. There were no other symptoms of rabies and he died fifteen days after onset. Rabbit inoculations were positive, with unicroscopic examination of cord negative.

The question of sensory changes is often variable. There may be no sensory changes or there may be very marked sensory findings. The sensory loss always corresponds to the area of muscle paralysis, with the paralysis appearing first. Anesthesia of entire extremity occurs, with hyperesthesia and loss of position sense having been reported.

The condition of acute transverse myelitis, Landrys syndrome and acute anterior poliomyelitis are often confused with rabies. The appearance of sensory changes always rules out anterior poliomyelitis.

Roy, in 1936, reported a case simulating acute transverse myelitis. The patient had onset of fever and pain over the upper part of body. On third day he was unable to move legs, following day complete anesthesia of skin up to level of umbilicus, with urinary retention. On the sixth day hydrophobia symptoms developed and the child died on the seventh day. This case gave a history of a dog bite eight months before, with no anti-rabic treatment.

Trinidad is well known in this field because of its suspected epidemic of poliomyelitis which turned out to be rabies. There were seventeen cases and were finally traced to the bite of infected vampire bats.

There seems to be some slight disagreement as to whether there is any relationship between the severity of the bite and development of paralytic rabies. However, it is generally accepted that paralytic rabies is more likely to develop after a minor and insignificant bite. Untreated cases of severe bites usually develop typical furious symptoms.

The duration of the inoculation period has no relationship to the development of paralytic forms. This varies from four weeks to ten months.

Reports show that sixty-five percent of paralytic cases become paralyzed first in the limb which received the wound and thirty-seven percent begin at a site other than where bitten. In general, paralytic rabies runs a less fulminating course than other types. Course of paralytic form is between seven and one half to twelve days, while in furious types the average course is three days.

Fever of 101° to 104° F. runs the entire course of rabies, often going higher near death. This also helps to rule out poliomyelitis in which fever drops to normal within three to five days.

The spinal fluid is of little value in diagnosis of rabies, there may or may not be increase in cells and globulin.

PATHOLOGY

The virus travels along the peripherial nerves fibers to brain and to certain glands. No functional disturbances are seen in these nerves. Upon reaching the brain, it enters the nerve cells and continues its growth. There is first stimulation of the cells, but later death of the cells take place.

At autopsy the gross findings are merely congestion of the brain, salivary glands, thyroid and pancreas.

The microscopic changes are very significant. In the spinal cord degeneration and inflammatory changes occur, chiefly in the segment of the spinal cord which receives the nerves from the site of inoculation. In 1892, Babes first described the "rabic tubercle". These are groups of small spheroidal cells surrounding many of the blood vessels, especially marked in the anterior and posterior horns. They are not always found and usually do not develop until late in the disease.

Characteristic "Negri Bodies" are inclusion bodies 1 to 30 microns in diameter, found in the cytoplasm of the nerve cell. They are usually oval in shape with eosinophilic cytoplasm with basophilic central granules. The number in a nerve cell varies from one to five. These "Negri Bodies" are found in the cells of the central nervous system. Due to the abundance of ganglion cells in the hippocampus (Ammon's horn) it is here that they are more likely to be found.

The exact nature of these "Negri Bodies" is unknown. They were first thought to be parasites, later on they were thought to be degenerative products. The latest work shows that they represent the etiologic agent in the form of virus colonies. As a rule the size and number are directly proportional to the duration of the disease. "Negri Bodies" are characteristic of rabies; however, they are not entirely diagnostic since they occur in various types of encepholomyelitis.

The neurones in the salivary gland sometimes show degeneration and necrotic changes and "Negri Bodies" are occasionally found.

There has been some recent work concerning the microscopic changes in the ganglion nodosum. Characteristic degenerative alterations of nerve cells, with or without inflammatory pericellular infiltration with marked proliferation of the capsular cells or satellites are now reported.

Examination of the ganglion nodosum, while not specific, are not found in this form in any other disease that must be considered in the differential diagnosis of rabies. One report shows that fifty percent of a certain group of cases "Negri Bodies" were not found in Ammon's horn by Lentz's method, although this ganglion showed changes described.

Men who have used this method of histologic diagnosis of rabies claim that diagnosis can be made in less than an hour using frozen sections. The time element in diagnosis of suspected rabid animals is very important in public health work in order that prophylactic treatment and proper control measures can be put to work as soon as possible.

Positive examinations of the ganglion nodosum is conclusive even if "Negri Bodies" are absent or can not be sought. If ganglion nodosum is negative, frozen sections of Ammon's horn, mesencephalon and medulla may then be done. If these are negative for characteristic changes of rabies encephalitis then animal inoculation is not necessary. In doubtful cases, inoculation of white mice should be done. This gives definite results in fifteen days.

Prompt and accurate diagnosis of rabid animals in the laboratory can not be over estimated. Extreme care should be taken in killing the animal, so as not to crush or shatter the brain, which would lead to contamination with bacteria and putrefaction. Careful packing of the head with preservation is desirable when mailing is necessary. Ice, 33 percent glycerine or borax are recommended preservatives.

Stomach examination of possible rabid animals is often helpful. If stomach and small intestine contain normal contents it is most likely that it did not have rabies. Quite often a rabid animal will ingest foreign material such as sticks, stones, leather and other material. It is necessary to note that diagnosis can never be made on stomach contents alone because normal dogs occasionally ingest foreign material.

The more rapid method of demonstration of "Negri Bodies" is by the smear method. If results by this method are questionable, sections should be cut and examined. There are numerous methods of staining smears and section. The Lentz method is preferred for diagnosis. It is possible by this method to prepare smears and section in three hours.

TREATMENT OF RABIES

The treatment of rabies is divided into two phases, local therapy and prophylactic immunization. Local treatment consists of cleaning the wound similar to any other open wound, plus cauterization. Fuming nitric acid is often used in cauterization.

The prophylactic treatment against rabies was introduced by Pasteur and has become known as the "Pasteur Treatment". Vaccines used throughout the world consist of emulsions of rabbit brain or spinal cord containing either living or filled fixed virus. The Semple method of phenol-killed vaccine is most commonly employed. This type vaccine has advantages of decentralization of treatment, infrequent neuroparalytic accidents and simplicity of manufacture.

Semple vaccine is prepared from spinal cord and brain of rabbits which have been infected with fixed rabies virus. The finished vaccine consists of a four percent emulsion of nervous tissue in physiologic saline containing phenol in 0.5 percent concentration.

The methods of administration will vary somewhat, but with the Semple vaccine it is recemmended that 2 cc. subcutaneously daily for a total of eighteen to twenty-five injections. Patients which were bitten on the extremity or trunk receive eighteen injections, where those bitten on the head, face or neck receive up to twenty-five injections. It is also believed best in substained, multiple or severe lacerations that twenty-five dosages be given. Because of minor local aseptic inflammatory reactions which not infrequently occur, it is advisable not to administer the vaccine in the same location on successive days.

Rabies virus is more resistant to phenol and glycerine than many bacteria. Hence, this is often used as a preservative and to get rid of contaminating bacteria. Pasteur's early preparations of vaccine were prepared by slow drying at moderate temperature (Twenty degrees C.). This greatly lowers virulence of virus. Harris used very rapid drying at freezing temperature which preserves virus indefinitely.

Pasteur's treatment is indicated in any person who has been bitten or scratched by a rabid animal or in whom the saliva of such an animal has reached any recent open wound. Anyone bitten or scratched by a stray dog in which the presence of rabies cannot be excluded should also be treated. In certain cases, especially in children, a definite bite or scratch by a rabid animal cannot be ruled out. The Pasteur treatment should be given, and certainly if rabies is known in the community.

There has been some fairly recent work in the use of ultra-violet irradiation in production of potent inactivated vaccine. A newly developed lamp which is a powerful source of both total and extreme ultra-violet (below 2,000 Angstroms) is used. This will completely kill or inactivate turbid suspension of bacteria or virus in a fraction of a second if a continuously flowing film with a depth of less than 1 m.m. being used.

This report stresses the importance of proper exposure to ultra-violet light in order that the vaccine will be satisfactory. Inadequate irradiation will not completely sterilize and inactivate, while over irradiation will destroy the immunogenic properties of the vaccine. Previous vaccines prepared by this method were faulty due to the technic because it was impossible to avoid over irradiation of a large part of suspension, while the rest was under-exposed; thereby, no consistency of results obtained.

Vaccines produced by this new method consistently induced a higher degree of immunity in mice than controlled phenolized vaccine. Another advantage claimed by this method is that it will not deteriorate on storage at ice box temperature. Phenolized vaccines do deteriorate somewhat on standing.

Soon after the use of rabies vaccine came into use, in rare instances neurological disturbances were re-

ported. These disorders varied from mild, transient and simple nerve weakness of cranial nerves to acute fulminating myelo-encephalitis and bulbar paralysis. In 1927 figures as high as sixteen percent mortality were reported in those cases treated. It would be almost impossible to say which were due to active rabies itself or whether vaccination played a part.

In the present day prophylactic treatment of rabies, the complications due to treatment are nothing similar to this. Some of the more common reactions that may occur include malaise, fever, backache, local erythema at injection site and urticaria. These are not serious and patient should continue with treatment when these mild reactions are seen.

It is generally believed today that fear of complications to prophylactic treatment has no place in the consideration in instances where treatment is questionable. There are occasional mild reactions to the vaccine but the advantages of treatment have been shown many times in the past.

In the J. A. M. A. in 1939 there was a brief discussion concerning paralysis due to rabies vaccine. They showed that 1 in 10,729 cases that some paralysis was noted. Further description was not given, but it is very rare that these are permanent. It must be constantly kept in mind that complications may occur and treated properly when detected.

A chart which is widely published giving the indications for antirabic vaccination is as follows:

A. If a man is (a) bitten by a dog (b) has uncovered skin soiled with froth or saliva, or (c) is scratched by a dog, it is not necessary to give antirabic treatment if the dog is known, or is observed promptly and shows no disturbance, provided it is known that there has been no rabies in the region for six months. If there is rabies in the district, it is advisable to start antirabic vaccination at once and to contniue it until the dog can be observed for ten days.

B. All other cases are handled as follows:

1. If dog dies in less than ten days after biting individual

Antirabic vaccination should be carried out.

2. If the dog is killed in less than ten days after biting

Antirabic treatment should be given.

- 3. If dog disappears
- 4. If the dog is unknown

Observe further.

- 5. If dog is living and is observed for ten days and:
 - (a) develops rabies
 - (b) dies under suspicious circumstances
 - (e) is sick, but lives over ten days
 - (d) remanis well at the end of ten day observation

Antirabic treatment should not be given.

IMMUNITY

While antitoxic immunity is satisfactorily explained on basis of humerol concepts, immunity in neurotropic virus disease such as rabies are known to be more complex problems. Immunization with the virus of poliomyelitis and rabies for instance leads to formation of antiviral antibodies, but here the immunized subject may not be protected against intra-cerebral or intra-nasal inoculation of virus. It has been shown also that even highly potent immune sera does not always provide passive protection when inoculation of test doseages are made intra-cerebral.

On the contrary with the virus of St. Louis encephalitis and equine encephalitis, active immunity can be produced without difficulty.

CONTROL

It has been known for many years how rabies may be eradicated but the question which always presents itself is how to apply what we know. It is here that much controversy has arisen which has led to confusion and lack of cooperation on the part of the public

The dog appears to be the natural host of the rabics virus and directly or indirectly, the main disseminating factor of the virus. Interruption of the cycle of rabies therefore involves the control of the disease in dogs.

The ideal control program involves a combination of destroying stray dogs and vaccination of all dogs. It is impossible to depend on vaccination of dogs alone. Webster, in 1939, found that many phenol treated vaccines did not protect laboratory animals. Hobel found wide variability in the protective action of commercial vaccines. He developed the "Hobel Test" of potency of vaccines which has been generally adopted as a prerequisite before offering any commercial vaccine for sale in the United States.

It has been shown that modern vaccination will greatly decrease the susceptibility of dogs, but the stray, homeless dog does not receive vaccination. It is here that public health authorities have met with the resistance of the dog owners' public. A single rabid dog becomes a local point of danger to both animals and community because of the tendency of the rabid dog to travel many miles before death occurs. Rabid animals have been known to travel as many as twenty miles. Thus we see here the number of possible contacts. It is necessary then, not only to be able to have immediate local control, but also of surrounding areas.

Several important procedures that must be set up in area in which an epidemic is likely:

- (1) Night and day quarantine on all dogs should be enforced.
- (2) Pick up and destroy all unwanted dogs.

- (3) Alert the public regarding the potentialities of rabies and request that pets are not allowed to run loose.
- (4) Report of all dog bites and have person exposed adequately treated.

Numerous plans for the control of rabies in a possible epidemic have been offered. One which has received wide consideration and use is as follows:

- A rabies advisory council which is made up
 of a state and county health officer, county dog
 warden, two dog owners, and a representative
 of the board of supervisors. The purpose of
 this council is to forestall any unjust criticism,
 offer suggestions and to see that proper steps
 be taken in whatever procedure be necessary
 to protect the public.
- 2. Public education and public relations board is very useful in order that people can understand the nature of the control program. It is essential to have complete cooperation between the public and those attempting the control of the disease. It is important that the publicity should be frank and correct in every respect. It has been found best to have one person in charge, through whom all material may come so that there will be no contradictory statements. Publicity may be carried out by means of radio, newspapers and posters if necessary.

Interpretation of the law, responsibility of dog owners and importance of early reporting on suspected rabid animals are other points that should be clear in the mind of the public.

3. Quarantine is one of the major methods by which the cycle of infection may be interrupted. Since it is known that a dog with furious rabies will travel many miles with many possible relationships with other dogs, it is necessary for any control program to quarantine all dogs in surrounding areas. Education of the public will go far in this phase of the control program. In an epidemic extra dog wardens will be necessary to see that proper care is taken of wandering dogs. Dogs which are picked up for suspicion of rabies are often referred to as seven days or four months dogs. That is, seven days to determine if infected with rabies or is suffering from some condition which it might be confused. The rabid dog will die in one week after onset of symptoms. Allowing dogs to die naturally increases chances of finding Negri bodies. In cases when a dog was known to have been bitten by a rabid animal, the most radical but safest procedure is to destroy the dog. Alternative to destroying it, is to watch the animal for four months.

4. Vaccination is a means by which rabies may be controlled to a considerable extent in dogs. This, together with vigorous destruction of stray dogs, will go far into the eradication of the disease. It is well known that vaccination will not give 100 percent protection. Immunity of vaccinated dog will not develop for one month and the dog may develop rabies during this time. In New York City, to aid in the control of rabies, recently the board of health required by law the vaccination of all dogs in the city. An amendment to the sanitary eode would make it a misdemeanor to keep a dog unvaeeinated against rabies and fines up to \$500. Enforcement is carried out by requiring proof of vaccination to get a dog license. It is well understood that vaccination must be under the supervision of qualified veterinarians.

RABIES IN SOUTH CAROLINA

While it is true that rabies epidemies have greatly declined in number and severity, here among many other public health problems, constant preventive measures must be enforced. With the realization of the potentiality of rabies and with the frequent occurance of isolated cases all over the state, the public health authorities must stand with full power to prevent its spread.

A recent report of the South Carolina State Board of Health showed that over a period of thirty-five years 53,000 people have received life saving vaccine following exposure to possible rabid animals. It has been shown that the yearly average for those receiving anti-rabie treatment in South Carolina was 3,165. Further reports of this state show that among 52,334 persons receiving treatment that thirty-seven deaths occured due to rabies. Among these, eighteen died because treatment began too late or due to the fact that treatment was not completed.

The latest report available shows that from July, 1942 to July, 1946, there were nine cases of rabies in humans, all of which resulted in death. Four of these had received no treatment; the other five, treatment was started too late.

It is well worth noting that among the 15,152 patients treated during this period, no complications were recorded due to the vaccine.

During a four year period (1942-1946) there were 935 animals examined by the state laboratories for rabies. Of these, 46.5 percent were found to be positive.

The old saying "one ounce of prevention is worth a pound of cure" certainly holds true in rabies, for there is no cure for rabies after the symptoms have once set in. The State Board of Health Laboratory is continuously distributing vaccine to be used in prevention of this disease. It is up to the physicians and

the public health officials to see that patients receive proper, early treatment.

For a comparative standpoint, in 1910 the death rate of exposed individuals was 1 out of 268 (1.35 percent) while in 1945 this figure had been reduced to 1 out of 2,754 (.036 percent).

The antirable vaccine used in this state consists of a freshly prepared 1:200 suspension of active fixed virus in 0.2 percent phenolized physiologic salt solution.

The prophylactic treatment in this state eonsists of one dose of this suspension injected subcutaneously daily for twenty-one days. The size of the dose varies according to the size of the patient and severity and location of the wound. Double dosages are advised for patients bitten on the face or head and for those who were exposed for as long as one week before beginning treatment.

CONCLUSION

The general subject of rabies has been discussed in attempt to bring forth a clear understanding of the disease. Brief accounts of the latest experimental work in this field has been brought out and where possible, the results of this work.

Rabies is a potential serious public disease and only through thorough knowledge of the process can the physicians of the state along with the public health authorities reduce to a minimum or stamp out altogether this preventable disease.

How to prevent this disease is known, but the application of our knowledge is difficult. Plans of eontrol used by other localities were outlined, showing that strict laws of Sanitary Codes are necessary, together with means by which these laws can be enforced. It is imperative that the public health departments be given laws that protect them in their efforts. There has been some public opinion against the fulfillment of strict control on pets. It is useless that a few sentimental pet owners due to their ignorance, jeopardize the health of others.

The prevalence of rabies in South Carolina was given and showed that this preventable public disease is far from solved and hopes that with proper methods this may show a decrease and eventually become a public disease of the past.

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CENTENNIAL MEETING

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FEBRUARY, 1948

AN OPEN LETTER

Dr. W. L. Pressly Due West, S. C. Dear Buck:

Last year we nominated you as South Carolina's candidate for the General Practitioner's Award of the American Medical Association, We were convinced that your position as a leader in your community and in your profession, and your service to the thousands of patients to whom you have ministered, entitled you to this honor.

When over two hundred nominations from all sections of the country had been received by the special committee, five were selected as outstanding, From these five, three were chosen by the Board of Trustees of the American Medical Association for presentation to the House of Delegates. Your name was one of these three. When the final vote was taken, you placed second.

We have nothing but praise and admiration for Dr. Sudan of Colorado who received the award. We feel sure that he deserves the high honor which was bestowed upon him and we wish we had the privilege of knowing him. But we also believe that had those who cast the ballots known you as we know you, the final vote would have been a tie or else slightly in your favor.

You have brought distinction to our Association and to your colleagues in this state—and for this we are truly grateful. Your life and work will continue to be an inspiration to all of us. We admire you for what you have done, we love you for what you are-a Christian gentleman, serving your fellowman as you walk in the footsteps of the Great Physician.

> Sincerely yours, The members of the S. C. Medical Association,

BENJAMIN RUSH

"What you need is a new perspective."

How often we feel that such an admonition is directed at us physicians. Beset by the daily routine of our work, taxed by the innumerable demands upon our time, harrowed by the needless worries of our patients and their families, aggravated by the inter-

minable ringing of the telephone-we begin to feel that all of life is one big rush with ourselves at the center of the whirl. First pondering and then magnifying the problems with which we are confronted, we come to see our friends, our community, our world, not as they really are but as they appear through our self-induced myopic eyes.

Our need, at such a time is to crawl from the rut which we have dug for ourselves-for what is a rut but a grave without the ends-and to rest our eyes, allowing them to look outward to the horizon and upward to the sky. And this is not hard to do if one will make the effort. The quiet of a shady stream with fishing rod in hand, the beauty of nature as one strolls through the woods or down the open fairway, the stimulation of conversation with intimate friends, the forgetting of self as one plays with boys and girls, the reading of a worthwhile book where the author shares with us his thoughts and his dreams, the solace of the eternal ages as one sits in the peaceful church pew-these are some of the rungs upon the ladder by which we may lift ourselves from the limited vision which we have allowed ourselves to develop and to acquire that healthy perspective which we so sorely need.

The train of thoughts expressed above were set in motion by the reading of a volume which has just come to hand, "The Selected Writings of Benjamin Rush". Here was a man who was a keen student of medical sciences and a leading physician of his day. How easy it would have been for him to limit his endeavors and his vision to affairs medical-but such was not his nature.

His was a progressive spirit. As a physician and as Professor of the Institute and Practice of Medicine at the University of Pennsylvania, he rejected medical orthodoxy and insisted upon progress through scientific research and daily observation. "Systems of physics are the production of men of genius and learning," he told his graduating class, "but those facts which constitute real knowledge are to be met with in every walk of life." That he practiced what he preached is attested by his writings and by the place which he holds in medical history,

Dr. Rush was not content to limit his work to

medicine but threw himself wholeheartedly into local, state and national activities. A burning patriot, he hated tyranny and along with such men as Tom Paine, was uncompromising in his advocacy of liberty. He was one of the signers of the Declaration of Independence. He championed the cause of the lowly and oppressed. He advocated better treatment for criminals and for the insane. He insisted upon good education for the masses. He argued in behalf of honesty and justice in government and he preached the gospel of the Christian religion.

His writings show a breadth of vision and a depth of understanding which, in his day, was second only to Benjamin Franklin. And—lest we forget—he was a hard working physician considered by many the leading physician of his day.

For the physician, who like ourselves, finds himself in need of a strong mental stimulant to rouse him from the intellectual lethargy which comes from confining work, we would suggest two or three evenings spent in the perusal of the writings of that pioneer American physician with his broad vision and revolutionary spirit, Benjamin Rush.

°The Selected Writings of Benjamin Rush, Edited by Dagobert D. Rune. Published by Philosophical Library, New York.

MEETING OF COUNCIL ON INDUSTRIAL HEALTH

The Council on Industrial Health of the American Medical Association held its Eighth Annual Congress in the Cleveland Auditorium, Cleveland, Ohio, January 5 and 6, 1948. The undersigned attended this meeting as a representative from the State Medical Association and the State Board of Health. The program of the Congress included discussions on nutrition, control of respiratory infections, physical examinations, administrative practices, applied physiology, aviation medicine, radiation medicine, and practical expositions of occupational disease management, traumatic surgery, and rehabilitation. The Council was formed in 1937. Dr. A. J. Lanza, New York City, is the Chairman.

An outstanding feature of the meeting was the exhibits. Approximately 150 firms displayed products developed specifically for implementing the work of the general practitioner and the industrial physician. There were clinics on cancer, dermatology, diabetes, and hearing demonstrations, with patients presented by Cleveland physicians.

Industrial health as a field of special medical interest is relatively young. However, it is obvious that industrial medicine and surgery is increasing in importance in this country. Some discussion was devoted to the advisability of providing a speciality board for industrial medicine with the necessary requirements for qualification. It was suggested that medical schools devote more time to industrial medicine at the undergraduate and postgraduate levels. The A. M. A. has given approval to residences in this particular field of

medicine. Hospitals and plant facilities will be used in connection with residences. It is believed that several medical schools in cooperation with the industrial medical departments of large plants will provide for additional residences in the near future.

Considerable time was devoted to rehabilitation of injured employees. This subject has assumed unusual prominence since the close of the war. This field also is pre-eminently a medical one and is likely to continue so for many years to come. Physical restoration is the fundamental principle in the rehabilitation of the crippled and disabled and this service can be adequately carried out only under medical direction and supervision.

Dr. Howard A. Rusk, Professor and Chairman of the Department of Rehabilitation and Physical Medicine, New York University College of Medicine presented an outstanding address on this subject. He referred to rehabilitation as the "third phase of medical care". The modern concept of this third phase of medicine takes the patient from the bed to the job. It was emphasized that a great many injured workers can become assets to their communities instead of liabilities if industrial physicians, surgeons and general practitioners will devote more time and attention to physical medicine.

Dr. Leo Price, New York City, reported on the comprehensive medical service for the ladies' garment industry. This organization has approximately 400,000 employees. Most of the industrial establishments in this country are small plants. Dr. Kenneth Peabody presented the plan of the New York County Medical Society for medical service in small plants. This plan was discussed at length.

Industrial physicians in the future will be confronted with additional medical problems due to radiation and radioactive material. These problems will deal with protection and definitive treatment whenever atomic energy is used extensively by industries. Considerable knowledge was accumulated during and since the war regarding this subject. However, it is believed that a requirement exist for additional research concerning the physiological effects and pathological manifestations of radioactive material. It was emphasized that industrialists will look to the industrial physician and general practitioner for guidance in providing a safe working environment when atomic energy is used by industry.

In conclusion, the meeting was interesting and informative. It is unfortunate that more physicians from this state did not attend.

> Harry F. Wilson, M. D. Chairman, Committee on Industrial Medicine.

SICKNESS STATEMENTS FOR RAIL WORKERS

Physicians throughout the Nation are being asked to furnish medical evidence to substantiate the claims of railroad workers who may now draw cash sickness benefits under the Railroad Unemployment Insurance Act. The Railroad Retirement Board pointed out that unless an application is mailed not later than the seventh day after the first day of sickness claimed, it may not be received within the legal time limit for filing applications. As a result, the employee may lose 1 or more days' benefits. Doctors are asked either to return each completed Statement of Sickness to the patient, or mail it promptly to the office of the Board to which it is addressed.

THE TEN POINT PROGRAM

M. L. MEADORS, EXECUTIVE DIRECTOR AND COUNSEL

LEGISLATIVE PROGRAM

The General Assembly has convened for its session of 1948. Matters uppermost in importance from the standpoint of members of the Association, are the Enabling Act for Medical Service Plans, the proposed investigation of the Naturopathic Board of Examiners, and the proposed changes in the organization of the South Carolina State Board of Health.

The South Carolina Medical Association does not, as such, propose to enter politics on a state or national basis or otherwise. It is, however, vitally interested in many things affecting the profession and the public at large. Its members, as citizens, are entitled and are obligated to take interest in what transpires in Columbia, and to actively use their influence as individuals when the opportunity arises.

It has been said before, but bears repetition, that the county Representatives are most vitally interested in the welfare and wishes of their own constituents, and will be found in their most receptive moods in the atmosphere of their own homes or places of business within the counties which they represent. The Legislators will appreciate the doctors' friendly interest in them and their work. The influence of the members of the medical profession individually, can be exerted for the general good of the State.

ANNUAL MEETING PLANS

Plans have been in the making for several months for the Association's Centennial meeting May 12th, 13th and 14th, 1948, at the Francis Marion Hotel in Charleston. The Committee in charge of arrangements, Dr. J. I. Waring, Chairman, are preparing to celebrate the 100th anniversary in proper style.

During December plans were perfected for the assignment of space for the commercial exhibits, and by the end of the year approximately two-thirds of the available exhibit booths had been disposed of. Because of the general lay-out of the Francis Marion, the exhibits will necessarily be scattered, and it is not too early to begin urging the members of the Association to take a little time out while at the Convention to visit those in which they are interested. In fact, it would be well if every member in attendance would make it a point to visit every exhibit at least once. It may be that some new and worthwhile idea may be found when least expected, which will

prove of genuine value to the physician. On the other hand, the presence of the Exhibitors and the amount they pay for the privilege of being there, are of substantial value to the Association and they are entitled to consideration.

BLUE CROSS GROWS

According to a recent report to the Board of Directors of the South Carolina Hospital Service Plan, November was the best month yet since it began operation. New enrollments during November were 4,062. This number, added to the subscribers previously enrolled, and after deducting certain cancellations, gave the Plan a net enrollment of 27,150 as of November 30th.

From a financial standpoint also, November looked best. The excess of income over expenses for the month was more than \$5,000, and this went a long way toward cutting down the operating deficit previously existing as a natural and necessary incident to the beginning of business. There has been a steady growth in the number of subscribers, and it is apparent that the development of the organization will be in line with that of other Blue Cross Plans throughout the country. As experience is acquired and additional hospitals in other sections are brought into cooperation, the South Carolina Hospital Service Plan will continue to serve the needs of the public of South Carolina on an ever increasing scale for the common benefit of the public, hospitals, and medical profession alike.

A recent national organization has been effected to include Blue Cross Hospital Service Plans and Blue Shield Medical-Surgical Service Plans. General Paul R. Hawley who, until recently, headed the medical division of the Veterans Administration under General Omar Bradley, has been named the Chief Executive Officer. General Hawley will be remembered by many physicians who have heard him speak on more than one occasion and his record in the Veterans Administration and in the military service is well known. It was under his direction in the Veterans Administration that the program of home town medical care for veterans was developed. The choice of General Hawley for his new position seems to portend an active and aggressive period of further growth for

Blue Cross and Blue Shield. It indicates also the position of the movement represented by these organizations as a national institution.

RICHMOND CONFERENCE

One of the most helpful and inspiring meetings it has been our pleasure to attend, was held in Richmond under the auspices of the Medical Society of Virginia on December 19th and 20th. On the afternoon of December 19th, representatives (Executive Secretaries and Public Relations Directors) from six of the southeastern states met in a conference on Public Relations at the Richmond Hotel, West Virginia, Florida, Louisiana, North Carolina, South Carolina and Virginia were represented. Also present and taking part in the discussion were Dr. Joseph S. Lawrence, Chief of the Washington Office of the Council on Medical Service of the AMA, and Mr. T. A. Hendricks of Chicago, the Council's Executive Secretary. The discussion was informal. Following a report from each state representative on the activities previously undertaken and planned for the future by his office, the conferees "took down their hair" and asked questions, replied frankly, picked up ideas and suggestions, turned them inside-out and examined them minutely.

The spirit and the purpose of the Conference was that of mutual assistance, all for one and one for all, in the effort to find ways and means for each to do the best job possible for his State Association and the profession at large. Members of Virginia's Committee on Public Relations had been invited to be present as observers and, of course, to offer suggestions. Dr. J. M. Emmett, the Committee Chairman, and Dr. H. B. Mulholland, Assistant Dean of the University of Virginia Medical School and a member of the AMA Committee on Rural Medical Service, accepted the invitation and added much to the meeting by their presence.

On the following day, Saturday, December 20th, the Virginia Medical Public Relations Conference was held. Those present, including about fifty members of the Medieal Society of Virginia together with the out-of-state representatives, heard discussions by members of Virginia's Committee on Public Relations, the State Commissioner of Health, and talks on about ten subjects of vital interest to the profession. The subjects included The Relationship Between the Private Practitioner and Public Health Officials, Significance and Possibilities of the Virginia Health Council, Voluntary Prepayment Medical Care and Hospitalization, The Hospital Construction Program in Virginia, and Suggested Public Relations Activities for Local Medical Societies. Prominent in the discussions was Dr. Walter B. Martin of Norfolk, a member of the Board of Trustees of the AMA. Dr. John T. Hundley's paper on the results of his inquiry into what the lay public thinks of the medical profession was one of the finest and most searching treatments of the subject

that it has been our privilege to hear. A copy has been requested and we hope to publish it in full in an early issue of the Journal.

The whole Conference was arranged and presided over by Mr. Henry S. Johnson, the very efficient Director of Public Relations for the State of Virginia. Only brief observation was necessary to realize the esteem in which he is held by the members of the State Society.

(The following article by U. S. Senator Wayne Morse of Oregon, which appeared as a guest editorial in a recent issue of the Wisconsin Medical Journal, is of interest to doctors in South Carolina as well as in Wisconsin. While it doubtless represents in large part a viewpoint drastically different from that of many members of the medical profession, it is important as an expression of the views of one of the leaders in the legislative branch of the National Government.)

HEALTH SECURITY WITHOUT BANKRUPTCY*

^oReprinted from the Wisconsin Medical Journal of October, 1947.

On July 11, 1947, in a speech in the Senate of the United States 1 endeavored to supply some answers to the question, "What do progressives in the Congress stand for?"

The charge is frequently made that we are negativists, that we only take a critical position on the reactionary program of the two major political parties and never offer anything constructive ourselves. Of course, the record of our proposals and of our fight to secure the adoption of our program, particularly in the Seventy-Ninth and Eightieth Congresses, does not support that criticism. Our chief difficulty is that we do not have the means or the resources for supplying the information to the American people about our program to any such degree as is available to those who represent a preponderant reactionary majority of the two major political parties.

However, time is on our side because time is going to pass by the retrogressive policies of those ultraconservatives of this country who are laboring under the mistaken notion that our private property economy, based upon the sound principle of a capitalistic democracy, can survive a return to the laissez-faire program of the 1920's. Much time, with corresponding progress and public enlightenment, has passed since the debacle of the 1920's. It was a debacle based upon the boom and bust theory of the business cycle. The economic patterns of the 1920's fed upon the economic fallacy enunciated by one United States Senator who spoke on the floor of the senate in 1946 against the Full Employment Bill by using the argument that economic depressions in this country are part of the price the American people pay for liberty. What a hopeless social philosophy was portrayed by that cruel argument. It is just such attitudes on the part of

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*Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154 Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60

Proc. Soc. Exp. Biol. and Med., 1934, 32, 241 N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592.

TO THE DOCTOR WHO SMOKES A PIPE: We suggest an unusually fine new blend-Country Doctor Pipe Mixture. Made by the same process as used in the manufacture of Philip Morris Cigarettes.

reactionaries in this country which give rise to classconscious conflicts and which too frequently, when the pendulum of public opinion swings too far over to the left, result in class-conscious legislation that does great wrong to the legitimate rights of the owners of capital.

Progressives Fight For Capitalistic Economy

Those of us in the progressive movement in this country seek only to strike that balance between too much and too little government entering into the affairs of our people. It is a delicate balance but one essential of accomplishment if we are to maintain our system of political and economic democracy, and we cannot have the one without the other. We cannot have political democracy without a capitalistic economy, and we cannot have a capitalistic economy without a political democracy. That clementary but fundamental political truth is being forgotten these days by both large numbers of so-called conservatives and large numbers of so-called liberals.

The truth of my observation can be simply tested by the question, "If you do not have a capitalistic economy what other kind of economy can you have?" The answer is a state economy, and I care not what you call it be it fascism, communism, socialism, or any other form of economic totalitarianism. Let every American citizen never forget that any form of economic totalitarianism carries with it the destruction of the individual rights and freedoms of the individual citizen, because under any form of economic totalitarianism the citizen becomes the servant and not the master of the state. Thus, it is inescapable that political democracy and our economic democracy, based on capitalism with its controlling principle of private property, are absolutely inseparable.

It is likewise important that not only every individual but all economic groups in this country, including the medical profession, recognize that one of the primary obligations of a political democracy, operating under a representative form of government, is to protect the economic weak from the exploitation of the economic strong but do it within the framework of our private property economy and in accordance with the tenets of our Constitution, including its precious Bill of human Rights.

The advocates of a laissez-faire economy, the political demagogues and reactionaries who, these days, are seeking to lead us back to the mistakes of the 1920's, forget that a laissez-faire economy is based upon the exploiting of the weak by the economic strong for profit dollars. A laissez-faire economy recoups itself upon the cruelties of economic depressions with all the mass unemployment and human suffering that flow from the boom and bust cycle.

Unfortunately, too many doctors in America, thinking of their own selfish, individual economic interests, give aid and comfort to the reactionary proponents of a laissez-faire economy. The moment anyone suggests that a representative government, based upon the principles of political and economic democracy, owes any obligation and responsibility to the people as a whole in seeing to it that minimum legislative safegnards are set up in the interest of the health of the people of the nation, too large a proportion of the American medical profession start crying to high heaven about socialized medicine and beating their breasts in self-righteous pronunciamentoes about free enterprise. No such lusty protestations are ever heard from the doctors when hospitals, clinics, and research laboratories are built with taxpayers' dollars and made available to the medical profession as the principal instrumentalities through the use of which they make their personal incomes from their practice.

I do not believe that either the cause of social justice or the right of the American people to fair dealing in regard to our national health problems is the least bit served by those in the medical profession who seem to feel that the doctors of America should be allowed to determine, without any interference or control by government itself, just what the American people are to receive from the medical profession in the way of medical service. Here again, time is bound to pass by such an attitude on the part of the American medical profession.

Public Health Greatest National Economic Asset

Thus, on July 11, 1947, on the floor of the Senate I pointed out that progressives stand for another great piece of social legislation, another principle of democratic government which it seems to me the politicians and the rest of the country might just as well recognize is a principle, the accomplishment of which is inevitable. It will require the passage of some more time, possibly, before it is fully carried out-it may require the passage of a considerable period of time-but it is sure to come as public enlightenment as the issue becomes more and more crystallized. The principle I refer to is that found in the position of the progressives in American politics when they say that the health of the American people and the state of their health will determine whether we are to be a nation of great assets or a nation of great liabilities.

We progressives take the position that the potential medical mortgage that hangs over the heads of the so-called middle class people in America is a great threat toward economic security. It is a great psychologic barrier which produces untold losses within our economy. It is the cause of great worry and concern in most of the homes of America because there is no denying the fact that a serious prolonged illness in the average American home can and frequently does wipe out the life-savings of the head of that home. Thus, there is developing a psychologic reaction toward the medical profession in this country that the doctors cannot afford to ignore.

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However, at the same time there is no ignoring the fact that right today another type of psychologic feeling on the part of the public toward the medical profession exists which makes the total attitude of the public toward the medical profession one of a paradox. Beloved as the medical profession is in the minds of the public, at the same time there is a deep psychologic resentment growing toward the doctors of the country not only because of the medical mortgage that they hold over the roofs of America like Damocles' sword but also because of a growing feeling that there are developing within the profession restrictive policies which are not making available to all the people of the country the full benefits of medical science.

Doctors Must Meet Public Demand

Hence, there is a growing trend of thinking on the part of our people that the government must do something about it. It undoubtedly will unless the doctors do something about it first. I say that because we are a political democracy, and although sometimes it requires a considerable passage of time for political trends to manifest themselves in final action, nevertheless, they inevitably do once the people as a whole reach the conclusion that they have stood more than they will further stand. Hence, on July 11, in my speech in the Senate, I also pointed out that it has been the position of the progressives in the Seventy-Ninth and Eightieth Congresses that we should endeavor to work out for the country a medical program that avoids the dangers of socialized medicine. That is why we have not become parties to any particular medical health bill which seeks in essence to have the government itself supply the medical care. I do not think that such a program is desirable, and I do not think it is necessary. But we cannot for long avoid adopting a sound program aimed at giving the health protection to which the American people are entitled and aimed at removing from the households of America the deadening psychologic fear that their life savings may be eaten up in one serious illness in the household.

We progressives have said over and over again to the medical profession, and I repeat it now, that it is up to the doctors of this country to come forward with a health program that will remove that fear and at the same time will keep medical practice on the basis of private enterprise. Irrespective of the unfair criticisms that many of the medical associations have heaped upon the progressives, I think they will find that their best, long-time friends are those of us who have been pleading the type of health program that is based upon the principle of political democracy which I have discussed in this article.

U. S. FINANCING OF MEDICAL STUDENTS GAINS SUPPORT*

Reprinted from Weekly Bulletin of the St. Louis Medical Society, December 19, 1947.

Most significant action taken by Association of State and Territorial Health Officers last week was its unqualified support of Surgeon General Thomas Parran's plan for Federal subsidization of medical students as a means of increasing the supply of physicians. Lending added importance is the fact that the idea, which Dr. Parran tested on Association of American Medieal Colleges six weeks ago, has the backing of Federal Security Administrator Oscar R. Ewing. At the proper time, it probably will draw White House support also and, as for Congress, it should not be unfavorably disposed—in an election year—toward a bill that would make it possible for young men and women in lowincome families to train themselves for medicine. ASTHO went further, adopting a strong resolution that Federal scholarships in dentistry, nursing and "allied fields", as well as in medicine, should be instituted to remedy "the increasing inability of institutions and students to meet the costs of professional training." Under the Parran plan, suecessful applicants admitted to accredited undergraduate medical schools of their choice would be obligated to spend a month in Federal service for each month of scholarship or, at the Government's discretion, in State or local public health duties. Still another alternative might be to assign such graduates to geographical areas most deficient in physicians. Before adjourning on Thursday their annual three-day assembly, the public health officers acted upon a wide range of problems. Recommended by the Association: Federal aid to the States to expand and extend local public health services; Federal grants in aid to medical schools; absorption of the Children's Bureau's health activities by U. S. Publie Health Service (a seheme with little chance of fruition, due to articulate opposition it would elicit from private organizations which want jurisdiction over maternal and ehild health matters retained by Children's Bureau); more loanouts of USPHS personnel to the States; establishment of a eoordinating eommittee on tuberculosis control with members representing American Public Health Association, National Tuberculosis Association, AMA, USPHS and ASTHO: improvement of USPHS laboratory serviees, including provision of a national Salmonella typing eenter, supply of rare biologicals to public health and other laboratories and ereation of a national virus and riekettsial identification center; relaxation of restrictions on lepers; renewed emphasis upon rabies prevention; retention of present bars

against interstate shipment of psittacine birds; continuation of Federal appropriations for the national school lunch program; nationwide promotion of the policy of applying sodium fluoride to children's teeth as anti-caries measure.

THE PRESIDENT SPEAKS

The following excerpts from the address of President Harry S. Truman to the Congress on January 7, 1948 will be interesting to members of the medical profession. Both matters to which he refers are subjects of pending legislation.

The greatest gap in our social-security structure is the lack of adequate provision for the Nation's health. We are rightly proud of the high standards of medical care we know how to provide in the United States. The fact is, however, that most of our people cannot afford to pay for the care they need.

I have often and strongly urged that this condition demands a national health program. The heart of the program must be a national system of payment for medical care based on well-tried insurance principles. This great Nation cannot afford to allow its citizens to suffer needlessly from the lack of proper medical care.

Our ultimate aim must be a comprehensive insurance system to protect all our people equally against insecurity and ill health. The Government's programs for health, education, and security are of such great importance to our democracy that we should now establish an executive department for their administration.

The President's reference to these matters in the foregoing words are indicative of further developments to be expected.

NEW MEDICAL CHIEF FOR VETERANS ADMINISTRATION

Announcement was made in the press on January 15th of the appointment of Dr. Paul B. Magnuson as Medical Chief of the Veterans Administration, succeeding Dr. Paul R. Hawley. The appointment is of interest to doctors generally, over the nation, particularly in those states like South Carolina which have developed a program of home town medical care for veterans, under contract with the Veterans Administration.

Dr. Magnuson has served under General Hawley for some time and is doubtless well equipped to carry on the further development of, and perhaps to effect improvements in the program. A native of St. Paul, Minnesota, he was at one time a surgeon in Chicago and immediately prior to joining the Veterans Administration in the early part of 1945, was Professor of Surgery at Northwestern University Medical School.

REPORT OF DELEGATE TO A. M. A. HOUSE OF DELEGATES

The Interim Meeting of the House of Delegates of the American Medical Association on January 5 and 6, followed by the first mid-winter meeting for General Practitioners on the 7 and 8, was held in Cleveland as planned. The attendance of this first mid-year meeting for General Practitioners was probably very good, there being some 3500 registrants. Naturally a large portion of these were from Cleveland and Ohio and nearby states. The program was an excellent one, with well arranged symposia on subjects of general interest. The speakers were noted American physicians, most of them teachers and outstanding clinicians, famous in some special field. The meetings were in a large auditorium with good acoustics. The subjects were dealt with in order, with a question and answer period after each symposium. Then a brief intermission to enable visitors to view the exhibits, both commercial and scientific, followed. The program was well organized and expertly managed. My only doubt after attending one such meeting, is that it will actually serve any really useful purpose that a well organized State Medical Meeting does not already do as well.

Perhaps we should not judge too quickly the success of this mid-year meeting for General Practitioners.

One of the most informative and interesting events at this meeting was the National Conference of County Medical Society Officers. This occurred the evening of January 6. Here were perhaps three hundred medical men who brought into discussion the real problems of the General Practitioner, such as hospital facilities and proper recognition of his abilities to do, for instance, tonsillectomies, simple fractures, uncomplicated obstetrics, etc. In many communities hospital appointments and beds are apparently not available to general men, and they are perforce required to refer their cases that need hospital care to men, usually specialists, with hospital staff appointments.

The House of Delegates met for two days and completed its work with unusual despatch. A committee to expedite work of the House was appointed last June and brought its report to this meeting. The changes are not dramatic but do call for certain changes, limitations and deletions that should improve the meetings. This report was approved and followed at this meeting. I think it will actually expedite the meetings of the House of Delegates.

The first order of business on Monday morning was

the nomination and election of the General Practice Award, We, in South Carolina, have every right to be proud of the fact that our Buck Pressly was one of the three outstanding men selected by the Board of Trustees, one of whom was to be elected for the Award by the House of Delegates. The Chairman of the Board of Trustees read brief sketches about these three men and without further discussion or any personal eulogies the House was asked to vote for the award. The winner, Dr. Archie Sudan of Denver, Colorado, was presented the gold medal on Wednesday night at a public meeting. At this meeting the Honorable Clinton P. Anderson, Secretary of Agriculture, delivered a splendid address. Following him the Award to Dr. Sudan was presented. As your Delegate I am sorry that Dr. Pressly did not win, and proud that he was runner-up in the final vote. It is my hope, and my suggestion, that we again nominate Buck for this great honor and present his name for this award next year.

Dr. Edward L. Bortz, President of the American Medical Association, made an excellent talk to the House. One of his suggestions was to encourage medical undergraduates to participate in organized medicine. He thought medical students and interns should attend County and State Meetings and that they should be instructed all along about medical and economic problems and encouraged to seek early affiliation with organized medicine. Dr. Bortz paid great praise to the medical auxiliary. His idea, and a sound one indeed, is that they are perhaps our most effective public relations experts and that accordingly they should be kept informed of various issues confronting our profession.

Dr. Elmer Henderson, Chairman of the Board of Trustees, made the report for the Board. We were informed that as a result of the great increase in all costs of operation the American Medical Association lost one hundred and seventy thousand dollars in 1947, and that with all possible retrenchments a deficit of one hundred thousand dollars for 1948 seems apparent. In view of this report of our serious financial status, the House of Delegates voted to increase Fellowship dues to twelve dollars annually which of course includes the subscription price of the Journal of the American Medical Association. This increase from eight to twelve dollars should increase our revenue to meet all expected expenses and keep the A. M. A. out of the red.

Dr. Henderson also reported on the meeting in Paris last fall to organize the World Medical Association. In September, 1947, our association agreed to subscribe fifty thousand dollars a year for five years with certain provisions, the most important one being that the Headquarters of this new organization must be in the United States where it can be free in fact. New York City was selected for this purpose. The German Medical Profession was not invited nor allowed to affiliate until they have condemned the horrible war practices of the recent Hitler regime and until they have regained the confidence and esteem of the Medical Profession of the World again. The purpose of the International Medical Association is to further International good will and better medicine.

The House of Delegates requested the appointment of a special committee of five, including two general practitioners, to study intern placing and adequate rotation plans in hospital training programs. This committee is to cooperate with the Council on Medical Education and hospitals and report its findings and recommendations at the annual meeting next June in Chicago. This may well become an important problem as we are rapidly returning to a normal number of medical graduates each year and there may soon develop a situation where there will be more approved internships and residencies than candidates. An equitable distribution would then indeed be important.

In the Journal of the American Medical Association for January 17, 1948, Volume 136 #3, pages 181 to 191, is a comprehensive report of this recent meeting of the House of Delegates. Here one may read briefly about all resolutions and discussions and readily familiarize himself with the work done in Cleveland. The report on association finances will answer your questions as to the increased cost of your Journal. The report on Hospitals and Practice of Medicine is informative. The report of the Committee on Nursing Problems is presented. It is only a progress report but indicates serious consideration of this problem.

I would recommend to every member of our State Association a careful reading of this report.

Respectfully,

Hugh Smith, M.D.

Delegate for South Carolina



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Pathological Conference, Medical College of the State of South Carolina

KENNETH M. LYNCH, M.D., PROFESSOR OF PATHOLOGY

ABSTRACT #601

Student Converse Presenting

PRESENT ILLNESS: The patient, a 38 year old negro man was found on his hands and knees by his bed shouting and screaming with pain in his head. He was placed in bed and soon lapsed into a coma. He was brought to the hospital in a comatose state shortly thereafter and was admitted at 8 A. M. in June 1947.

PAST HISTORY: (from clinic records)

First clinic visit in 1935 for bilateral suppurative inguinal adenopathy developing 3 months after "running range". Next admission in July 1945 for bilateral leg ulcers. Wassermann positive and he received a course of mapharsen and bismuth (9 injections of marpharsen and 14 injections of bismuth) following which the Wassermann continued positive.

PHYSICAL EXAMINATION: T-98 P-58 R-20 BP 290 170.

A well developed and well nourished comatose negro male who occasionally threshes about. Respirations stertorous. Right pupil smaller than left, but both constricted and reacted slowly to light. Eyes roll about and there seemed to be no ocular paresis. Right facial weakness. Neck not stiff. Ears, nose and throat normal.

Heart and lung sounds were partially obscured by ronchi but did not seem abnormal.

Abdomen-wall relaxed. No masses felt.

Patient able to move all extremities, but for the most part keeps the right arm and leg limp and these extremities were weaker than those on the left.

Muscle and tendon reflexes equal bilaterally except for a positive Babinski on the left,

LABORATORY DATA:

6/29 RBC 3.9 million. WBC 13,000. Hgh 12.5 PMN 92%. Spinal fluid pressure 510 mm. Fluid grossly bloody, but did not clot. 28% of RBC were crenated.

COURSE IN HOSPITAL: Lumbar puncture performed without difficulty. Spinal fluid spurted for about 10 ft. before manometer attached. 10 min. after spinal tap patient had a tonic convulsion with rigidity of all extremities and mild opisthotonos. Developed Cheyne-Stokes respiration. At 9 P. M. on the day of admission his respirations were 50/min. and he had a B.P. of 220/150 and pulse of 120. Two and a half hours later his BP was not obtainable, pulse 112, respirations 44. He died one hour later.

Dr. James O'Hear conducting

Dr. O'Hear: Mr. Efron, please give us your analysis of this case.

Student Efron: All the indications in this case point to a cerebral vascular accident. There are quite a few etiologic factors which may be responsible for this and they are difficult to differentiate because of the lack of a past history. I considered the following possibilities: Essential hypertension with arteriosclerosis and cerebral hemorrhage; Syphilitic cerebral endarteritis; Berry aneurysm and brain tumor. In evaluating the part that hypertension plays in this case, it would be necessary to know if the patient had an elevated blood pressure prior to his present illness. If he had, the high blood pressure reading that is recorded here may indicate that the hypertension had entered into a malignant phase with resultant cerebral hemorrhage. He may have had a syphilitic endarteritis of the lenticulostriate artery with a small rupture and thrombosis. When the spinal tap was done a clot in this vessel may have been loosened by the decrease in intracranial pressure and massive hemorrhage with interventricular rupture occured. I think this would explain the quantity of blood in the spinal fluid, the elevated blood pressure and the slow pulse. More complete studies of the urine and eye ground examination would aid in evaluating the hypertensive state.

Dr. O'Hear: When you see a Negro man with leg ulcers, what disease should you think about?

Student Efron: Sickle cell anemia. Cerebral manifestations of a sickle cell crisis might produce this picture, but we have no sickle cell studies or other data to point in this direction.

Dr. O'Hear: Mr. Gregg, do you agree with what has been said?

Student Gregg: I think it is likely that he had syphilitic endarteritis with thrombosis and rupture of the vessel. The latter would be particularly likely if he had a pre-existing essential hypertension.

He may have simply had hypertension with gradual increase over a period of years with accompanying sclerosis of cerebral blood vessels and final rupture. About 35% of patients with hypertensive disease eventually die of cerebral vascular accidents.

Dr. O'Hear: What does essential hypertension mean?

Student Gregg: It means that there is no organic cause discernable.

Dr. O'Hear: What is the significance of crenated red blood cells in the spinal fluid?





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Student Gregg: A number of crenated red blood cells is an indication of the age of the hemorrhage. The number of non-crenated cells here indicate that the blood in the spinal fluid has only recently escaped there.

Dr. O'Hear: Mr. Massey, do you have any different ideas?

Student Massey: There is no proof that he had a pre-existing hypertension, but it is a good possibility. I think he probably had rupture of a vessel of the circle of Willis most likely at the site of a berry aneurysm. The likelihood of such a lesion blowing out would be increased if there was a previous hypertension. I don't believe that he had rupture of a vessel within the brain substance because there is insufficient evidence of definite paralysis. A possibility of a mycotic aneurysm must be borne in mind that there are no indications that he had bacterial endocarditis or other source of infected emboli.

Dr. O'Hear: Mr. Poliakoff, what is your diagnostic choice in this case?

Student Poliakoff: I don't feel that syphilis is the basis for his trouble and there is no history indicative of trauma or cerebral tumor. Rupture of a congenital aneurysm appears most likely to me. Malignant hypertension does develop in this age group with rapid elevation of blood pressure and I believe he must have had some degree of hypertension prior to the present illness, although, it is not necessarily the whole story.

Dr. O'Hear: Why don't you think he had a normal blood pressure to begin with?

Student Poliakoff: I think he has too high a degree of hypertension.

Dr. O'Hear: Does any other student have anything to add?

Student Richards: In analysing this case it is important to differentiate whether or not the hemorrhage is intra- or extra-cellular. I believe he probably had intracerebral hemorrhage because there is some tendency toward localization. The low temperature also goes along with intracerebral hemorrhage.

Dr. O'Hear: Do any members of the faculty have an opinion to express?

Dr. Kredel: I think the initial onset of headache and the lack of well developed hemiparesis indicates free subarachnoid hemorrhage. I agree that the hypertension is quite high for the ordinary case of cerebral hemorrhage.

Dr. Boone: The question here resolves itself into differentiation between subarachnoid and intracerebral hemorrhage. It is indeed a sad state of affairs that a patient should have been seen so frequently in clinic and still not have any record made of his blood pressure. I believe he had a luetic or berryaneurysm of the circle of Willis with rupture.

Dr. Moseley: Leg ulcers as a part of syphilis do not occur except as the result of gummas. They do occur in sickle cell anemia, however, but cerebral lesions in this disease are a result of thrombosis and cerebral softening and are a much slower process than indicated here. I think that the patient probably had intercranial hemorrhage on the basis of hypertension and atherosclerosis.

Dr. Cannon: Final Pathological Diagnosis: Congenital Aneurysm, Ruptured, of Left Middle Cerebral Artery with Hemorrhage, Subarachnoid and Intracerebral.

Here you see the brain which shows marked flattening of the cerebral convolutions with almost complete obliteration of the sulci. There is a massive subarachnoid accumulation of blood over the inferior aspects of the frontal and temporal lobes and which is more marked on the left side. Along the course of the left middle cerebral artery, 2½ cms. from the origin of this vessel, is an aneurysmal sac measuring approximately 3 mm. in diameter. This is ruptured and surrounded by clot. Adjacent to it is a hematoma within the substance of temporal lobe. On horizontal section of the brain you can see that this blood clot has dissected through the cerebral substance in the region of the insula and has eventually ruptured into the posterior horn of the lateral ventricle on this side.

There was no hypertrophy of the heart or changes within the arterioles of the kidney that would indicate that this man has any pre-existing hypertension.

MEDICAL SUMMARIES

THE ANTIHISTAMINIC DRUGS, PHARMACOLOGY AND THERAPEUTIC EFFECTS

Samuel M. Feinberg

Am, J. M., 3: 560-570. Nov. '47.

An evaluation of experimental findings as well as clinical experiences with a number of antihistaminic drugs, some of which are already available to the general medical profession and one or two others which are still in the trial stage. These include Benadryl, Pyribenzamine, Neoantergen (manufactured in France), Antistene (Ciba, Switzerland) and Thenylene (Abbot) and Histodyl (Lilly). The last two have essentially identical chemical formulae. These compounds are the outgrowth of studies in phenolic ethers and the ethyelne diamine radical. There is at least one benzene ring in each of them. They inhibit histamine shock, prevent bronchospasm following exposure to histamine aerosols in guinea pigs, prevent the depressor effect of histamine on blood pressure, inhibit whealing action of histamine, specific antigens and other whealing substances. They also possess a local anesthetic action, act as cerebral excitants in large doses and some of them have an atropine-like action.

Clinically these drugs offer symptomatic benefit to patients with allergic rhinitis, urticaria, atopic dermatitis and many forms of pruritis. They are not very effective in migraine. Most observers agree that there is no tendency for cumulative effects or persistance of action after the drug has been discontinued, even after prolonged period of administration. The effect of one dose may be effective for one to several hours. They should not be used to prevent an anticipated allergic episode.

Ointments of these drugs may be of value in itching dermatoses; acrosols or Pyrabenzamine may be of some aid in allergic coughs. Unpleasant side actions are frequent. These probably occur most often with Benadryl. Side actions include sedation, dizziness, dryness of the month and nose, weakness, headache, insomnia and gastro-intestinal disturbance.

More serious toxic actions such as granulocytopenia (with Pyribenzamine) have been described. The possibility of such reactions must be kept in mind.

The author emphasizes that these drugs are not completely effective and are at best palliative. They are not sutstitutes for other antiallergic drugs such as epinephrine, tphedrine, aminophylline and iodides. Specific allergic management by methods of avoidance and desensitization is recommended.

CHILDBEARING AND PULMONARY TUBERCULOSIS

C. I. Stewart and F. A. H. Simmonds

Brit. M. J., Vol. 2: p. 726-729, Nov. 8, 1947.

The authors attempt to determine what influence, if any, childbearing has upon the course of pulmonary tuberculosis in those in whom the disease was found during the early months of pregnancy and in those in whom the disease has been previously found. The effects of rearing the infant on these mothers is not studied. Some 236 pregnancies were studied. Of these 166 or 70.3% had arrested or quiescent tuberculosis. The records were inadequate to classify the activity of the disease in 8.4%. A control group of about the same size was also studied. Clinical notes and X-rays were obtained in every case. Sputum studies and gastric washings were obtained whenever possible. Over a 15 months' period some 30 to 40% in each group including the control group had deteriorated or died.

The authors make the broad deduction that in general, a single pregnancy has little or no effect upon the course of tuberculosis whether it be progressive or quiescent. Patients whose pregnancy is artificially terminated seem to do better than those who are allowed to go to term. However, it is stressed that the individual case must be considered. Pessimism as to the influence which pregnancy has on tuberculosis should be avoided.

Deterioration in the state of some tuberculous patients must be expected whether the patient is pregnant or not.

OBSERVATIONS ON MORTALITY FROM ACUTE APPENDICITIS AT A UNIVERSITY HOSPITAL 1916 TO 1946

Rudolph N. Schullinger Ann, Surg. 126:448-471 Oct. 1947

A report of 5, 405 cases of acute appendicitis and its associated lesions between 1916 and 1946 is discussed. The total death rate was 3.55 percent but during the last 5 years, the mortality was only 1.37 percent. These statistics are comparable to those of other similar hospitals. Deaths varied from .49% with simple acute appendicitis to 82.35% with acute appendicitis and progressive fibrinopurulent peritonitis.

Numerous reasons for reduction in appendicitis deaths include: (1) consciousness of the dangers of delay and purgation by the laity, (2) early recognition of the disease by the physician (3) great advances in preoperative preparation, fluid balance, anemia, and

hypoproteinemia, (4) use of plasma, blood, oxygen, gastrointestinal decompression, (5) prevention and care of thrombophlebitis, (6) early ambulation, (7) advances in anesthesia and operative technique, (8) penicillin and sulfonamides, (9) judgment, skill, experience, the observance of fundamental precepts and sound surgical principles.

The author's policy is prompt operation but several hours preparation may be necessary in some cases for resuscitation and fluid balance. Spinal anesthesia is favored. Speed is desirable at times but not at the expense of technical precision and gentleness to the tissues. A liberal McBurney incision is recommended, but other types of incisions may be indicated. Inversion of the stump or simple ligation is preferred, but the combined ligation and inversion method is condemned. Adequate drainage when indicated is strongly recommended in spite of modern chemotherapy and antibiotics. Medical consultation should be secured early when complications arise.

THE CHEMOTHERAPY OF URINARY TRACT INFECTIONS IN THE ELDERLY

W. L. Hewitt

Geriatrics 2: 334-343, Nov.-Dec. (1947)

The greater frequency of urinary tract infection in the elderly as compared with the younger age group is well known. The increased incidence of diabetes mellitus, obstructive uropathy, foreign bodies in the urinary tract such as calculi, the decreased renal function of the aging process; and the role of pyelonephritis in initiating and continuing a pathological process resulting in renal insufficiency, accentuate the importance of prompt attention and proper management of this type of infection.

The choice of a chemotherapeutic agent should be largely determined by the type of bacteria present in the urine. Gram negative bacilli are the most common ctiological agents but gram positive cocci may also be present in pure culture or in mixed infection. Mixed infection is probably more common than is suspected.

Necessary prerequisites for successful chemotherapy of urinary tract infection are the presence of a free flow of urine without obstruction, drainage of localized accumulations of exudate, absence of foreign bodies within the urinary tract or of wounds with granulating surfaces communicating with urinary tract. Renal function sufficient to secrete the chemotherapeutic agent in bactericidal concentrations in the urine is also necessary.

Mandelic acid has been largely supplanted by newer more potent drugs. It is still useful however in treatment of infections with *Str. fecalis* and the occasional infections with *E. coli* which are resistant both to sulfonamides and to streptomycin.

Sulfathiazole and sulfadiazine are effective against almost all of the common bacterial pathogens isolated from the urinary tract. Large doses are unnecessary except in the presence of *Str. fecalis* or *Proteus sp.* or when bacteremia coexists with infection of the urinary tract. The use of sulfonamide mixtures as a possible method for reduction of renal complications is suggested. Mixtures of sulfadiazine and sulfamerazine are probably best since sensitivity to one of these drugs is almost always coexistent to the other, whereas sensitivity to sulfathiazole coexists with sensitivity to sulfadiazine in only 15% of cases.

Penicillin is the most potent agent for the eradication of gram positive cocci in the urinary tract as well as for the treatment of metastatic suppurative complications arising in the urinary tract during infections with these bacteria. In the presence of mixed infection with gram-negative bacilli, combined treatment with sulfonamide or streptomycin is indicated.

Streptomycin is effective against most of the gramnegative bacilli encountered in urinary tract infections. Moderately or highly resistant cultures of *Str. fecalis* are indications for increased dosage.

Alkalinization of the urine is an important adjunct to streptomycin therapy.

COMPARATIVE STUDY ON THE USE OF THE PURIFIED DIGITALIS GLYCOSIDES, DIGOXIN, DIGITOXIN, AND LANATOSIDE C, FOR THE MANAGEMENT OF AMBULATORY PATIENTS WITH CONGESTIVE HEART FAILURE

R. C. Batterman and A. C. DeGraff Am. Heart J. 34: 663-673 Nov. 1947.

Considerable attention has been focused recently upon the use of the purified digitalis glycosides. In the authors opinion the maintenance of the digitalized state is the most important aspect of the management of the patient with congestive heart failure and a careful study of the efficacy of the various glycosides was undertaken. A group of 74 ambulatory patients were studied. All of them required the daily administration of a digitalis preparation to be maintained in a state of satisfactory compensation. The authors found that for reason of safety in administration and satisfactory maintenance, digoxin is the glycoside of choice. Lanatocide C administered orally is not satisfactory for the routine daily management of the patient with congestive heart failure. The incidence and degree of toxic symptoms are the same for the three glycosides. The duration of toxicity is much greater with digitoxin than with lanatocide C or digoxin. Batterman and DeGraff point out that other than the assurance of obtaining uniformity in various lots, the glycosides have no advantage over the digitalis leaf. The exception to this is the occasional patient who cannot tolerate the digitalis leaf because of local gastrointestinal irritation or the psychologic factor of taking digitalis.

The purified glycoside will not result in more efficient or safer digitalization. The toxic manifestations, which may differ in duration, are generally the same for the glycosides and digitalis leaf.

DEATHS

Dr. Dove Walter Green, 60, of Conway, died at the Naval Hospital in Charleston, January 16, following an extensive illness.

A native of Charleston, Dr. Green received his education at the Medical College of the State of South Carolina (Class of 1912). For a period of thirty-one years he carried on a general practice in Mullins and Conway. During his later years he secured special training in ophthalmology and otolaryngology and devoted a large part of his time to these specialties.

Dr. Green was a veteran of World Wars I and II and during the latter war served at the Charleston Naval Base.

Dr. Green was highly popular with his patients and with his colleagues and his loss is keenly felt. He is survived by his widow, the former Miss Irenc Hardwicke, five daughters and one son.

Dr. George L. Kennedy, 53, died at his home in Ninety-Six on January 12. He had been in poor health for a year.

A native of Blackstock in Chester County, Dr. Kennedy received his education at Presbyterian College at Clinton and the Medical College of the State of South Carolina (Class of 1917). In 1925 he located at Ninety-Six where he carried on a general practice.

In addition to his medical work Dr. Kennedy was keenly interested in his community and a participant in its affairs. He was a Deacon in the Presbyterian Church and a Trustee of the School system.

Dr. Kennedy is survived by his wife, the former Miss Elizabeth Tennent, two daughters and two sons.

Dr. William Jerdone Pettus, retired United States

Public Health Service Senior Surgeon, died in Charleston on December 28, at the age of 85.

A native of Virginia, Dr. Pettus was graduated from the Medical College of Virginia (1884). Following a long term of service in the U. S. Public Health Service, he retired to Charleston where he lived until his death. Dr. Pettus is survived by several nieces and nephews.



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NEWS ITEMS

Dr. Archer Chester Sudan of Colorado was awarded the General Practitioner's Award at the recent meeting of the American Medical Association at Cleveland. Runner-up in the voting was our own Dr. W. L. Pressly of Due West. Dr. Sudan was for twenty-one years the only physician in a Colorado mountain county of 1867 square miles with a population of about one thousand.

Dr. I. H. Grimball has been elected President of the Greenville General Hospital staff and Dr. David Watson has been named President of the staff of St. Francis Hospital (Greenville).

Dr. M. R. Mobley has been elected President of the staff of the McLeod Infirmary (Florence).

Dr. Irving S. Barksdale of Greenville was recently elected an active Fellow of the American College of Allergists.

Under the direction of Dr. J. Warren White six physicians are now receiving special training in orthopedics at the Shriners' Hospital in Greenville, A part of their training is also being received at the Greenville General Hospital and the Spartanburg General Hospital.

Dr. and Mrs. J. William Pitts of Columbia announce the arrival of a son at the Providence Hospital on December 5, 1947.

Dr. Roger Doughty of Columbia was elected Vice President of the Southern Surgical Association at its recent meeting in Florida.

Congratulations are in order to the following men who have been elected presidents of their county societies:

Dr. J. I. Waring, Charleston.

Dr. Chapman J. Milling, Columbia. Dr. T. G. Goldsmith, Greenville.

Dr. Harold S. Gilmore, Nichols (Pec Dee Medical Society)

Dr. C. E. Ballard, Pickens. Dr. A. C. Wise, Saluda (Ridge Medical Society) Dr. T. G. Hall, Westminster (Oconee) Dr. R. W. Lominack, Newberry.

A joint meeting of public health officers, nurses and educators of the Piedmont section was held recently at Saluda.

A paper by Dr. Rowland F. Zeigler, Jr. of Florence, which was printed in the Journal of the North Carolina Medical Association, evidently made quite an impression since the Mississippi State Board of Health has asked for a sufficient number of reprints to send to all of their personnel. The title of the paper is 'Preeclamptic Toxemia of Pregnancy".

Dr. James Keith Palmer of Sumter, a graduate of the Medical College of the State of South Carolina, recently was awarded the degree of Master of Science in urology by the University of Minnesota.

R. M. Pollitzer of Greenville, S. C. addressed the Medical History Club of Charleston on January 8,

1948 and presented a paper on "The Renaissance and Some Renaissance Doctors.

MISSISSIPPI VALLEY MEDICAL SOCIETY 1948 ESSAY CONTEST

The Eighth Annual Essay Contest of the Mississippi Valley Medical Society will be held in 1948. The Society will offer a cash prize of \$100.00, a gold medal, and a certificate of award for the best unpublished essay on any subject of general medical interest (including medical economics and education) and practical value to the general practitioner of medicine. Certificates of merit may also be granted to the physicians whose essays are rated second and third best. Contestants must be members of the American Medical Association who are residents of the United States. The winner will be invited to present his contribution before the Thirteenth Annual Meeting of the Mississippi Valley Medical Society to be held in Springfield, Ill., Sept. 29, 30, Oct. 1, 1948, the Society reserving the exclusive right to first publish the essay in its official publication—the MISSISSIPPI VALLEY MEDICAL JOURNAL (incorporating the RADIOLOGIC_REVIEW). All contributions shall be typewritten in English in manuscript form, submitted in five copies, not to exceed 5000 words, and must be received not later than May 1, 1948. The winning essay in the 1947 contest appears in the January 1948 issue of the MISSISSIPPI VALLEY MEDICAL JOURNAL (Quincy, Illinois).

Further Details may be secured from Harold Swanberg, M. D., Secretary, Mississippi Valley Medical Society, 209-224 W. C. U. Building, Quincy, Illinois

CORRESPONDENCE

January 8, 1948

Dr. Julian Price, Florence, S. C. Dear Dr. Price:

At a meeting of the Executive Committee of the South Carolina Division of American Cancer Society held in Columbia on December 17 I was instructed as Chairman of the Executive Committee to advise members of the medical profession that funds of the cancer society were available for establishment of cancer detection centers. Funds for this purpose are not large but a decision was reached to grant \$1,000.00 to any detection center which could meet the requirements of American Cancer Society. As you no doubt know these centers have proven quite popular throughout the country. In 1946 there were only 18 such centers in operation in United States. During last year this number was increased to 181 and the cancer society of many of the states are following the practice of allocating some of the funds which are raised by public subscription to establish and maintain such detection centers. As you know the detection center is unique in that it is not for people with known or suspected cancer but for well people who wish a or suspected cancer but for well people who wish a thorough, complete physical examination in order that they may learn if they have any early symptoms of beginning malignancy. The American College of Surgeons at the request of the American Cancer Society have set up standards for such detection centers. (These requirements may be had from American College of Surgeons on request.) At the meeting of our State Medical Society last spring the House of Delegates approved the establishment of such detection centers with the understanding that the organiza-

tion and operation of the centers be worked on a county level. In order then for the doctors of any county to set up a cancer detection center in their hospital the proper procedure would be for the County Medical Society to approve the idea and then elect from its members a cancer committee who would be empowered to work out the details of organization and operation of the detection center. The society would then elect a small group to staff the organization and this staff together with the cancer committee and hospital authorities would work out such details as time and place of meeting, etc. \$1,000.00 has been allocated to detection center at Anderson Memorial Hospital which will begin operation at an early date. If any other county medical society in the state wishes to establish and operate a detection center the above described steps should be taken and then the officials of the local county unit of South Carolina Division of American Cancer Society should make out a project requesting a \$1,000.00 grant for the operation of the detection center. For the executive committee to approve this project we will have to have evidence that the minimum standards as set up by the American College of Surgeons can be met.

We will appreciate it if you will publish this letter in the next issue of the South Carolina Journal.

Thanking you and with best wishes for the New Year.

Lam.

Yours very truly, J. R. Young, M. D. Chairman of Executive Committee, S. C. Division.

VETERANS ADMINISTRATION

Regional Office Fort Jackson, S. C. January 6, 1948

Dr. Julian F. Price 105 W. Cheves St. Florence, South Carolina Dear Dr. Price:

The state-wide program for furnishing medical service to veterans has been in operation for approximately one year. It appears fitting at this time that we of the Veterans Administration who have been responsible for administering the program express our appreciation for the splendid cooperation we have received from the physicians in South Carolina. The plan was new and untried and there have been "bugs" which we have tried to eliminate. There has been a great deal of publicity both in the press and on the radio given the matter, much of which was misleading and much of which was misinterpreted. This has resulted in misunderstandings and I am sure has tried your patience many times. I have frequently heard the charge "Government red tape." A concerted effort has been made by those administrators charged with the responsibility of policy making for the Veterans Administration to eliminate as much red tape as is consistent with Federal laws. However, any matter which has to do with the obligation of Federal funds will always involve red tape. That is as it should be. No person charged with the responsibility of obligating public funds should take the responsibility lightly.

I should like to again take this opportunity to caution physicians about reporting promptly any



treatment rendered veterans. Regulations provide that Out-patient treatment may be furnished veterans for a service connected disability if emergency or urgent treatment is indicated and this office is notified within 15 days. This report should be forwarded at once as there may be delays in the mail or otherwise. If treatment of a service connected disability is not of an emergent or urgent nature, no treatment should be rendered until formal authority has been issued. It is especially important that bills be rendered promptly for services rendered on any authorization. It is equally important that we be notified promptly if no services are rendered on an authorization since funds to cover each authorization arc encumbered by the Finance Division and may not be used for any other purpose until we are advised that no bill will be pre-

Again assuring you of our appreciation for your splendid cooperation in this program, I am

Very truly yours, D. B. WILLIAMS, M. D. Chief Medical Officer

WOMAN'S AUXILIARY SOUTH CAROLINA MEDICAL ASSOCIATION

President: Mrs. D. F. Adcock, Columbia, S. C.

Publicity Secretary: Mrs. Kirby D. Shealy, Columbia, S. C

The Woman's Auxiliary of the Columbia Medical Society was host to the national president of the Woman's Auxiliary of the American Medical Associa-tion, Mrs. C. A. Allen of Atlanta. Mrs. Allen addressed the local auxiliary at a luncheon at the Columbia Hotel.

Mrs. Allen spoke of the vast growth of the many auxiliary organizations over the nation stating that 44 states and the District of Columbia are now organized. She also recounted her travels since her installation as president last June. She has flown 18,000 miles since then and has covered almost all of the organizations of the states.

She paid especial tribute to the South Carolina organization and commended them on their publication which, she said, is the only auxiliary publication

in the south.

"The day is past when doctor's wives have no part in their husbands' practice," she said. "We speak the layman's tongue, our husbands do not and it is our place to see that the correct lay interpretation of the science of medicine is before the people who are our husbands' patients.

She also made an appeal to the membership to take, individually, high school students who are graduating and be responsible for their entering nurses training as a relief measure for hospitals. She suggested desirable means of approaching the students and guiding them in their decision.

Mrs. Allen is the first national president from the South since 1928.

She was presented with an autographed copy of "Beneath So Kind A Sky," the recently published book by Carl Julien and Dr. Chapman Milling.

A resolution that the auxiliary should participate fully in the recruiting of nurses was presented by Mrs. W. P. Beckman. The resolution provides that members shall exert every possible effort to obtain nurses for training in hospitals for eventual relief of the present shortage of nurses which is keeping many beds vacant.

Present at the meeting which was presided over by Mrs. Manly E. Hutchison, president were 27 out-of-town guests and 75 members.

PICKENS AUXILIARY HEARS MRS. ADCOCK

The Pickens County Medical Auxiliary held its December meeting on the 11th at the home of Mrs. L. R. Poole, Easley. The lower floor was beautifully decorated in the traditional Christmas designs.

The meeting was called to order by the president, Mrs. C. E. Ballard, who greeted the visitors, Mrs. D. F. Adcock and Mrs. L. C. Davis of Columbia, and Miss Zoie St. Amand of Summerville.

Mrs. Roy Gaston gave the devotion, using the nativity scene as the theme, followed by prayer.

Reports on cancer and T.B. work and the usual

routine of business was heard.

Gifts of toys and food were brought to be dis-tributed amongst the needy at Christmas, and bottles of vanilla were given members to sell, the money to be used by the Auxiliary for any purpose voted on by the members.

Mrs. Ballard presented the guest speaker, the state president of the Woman's Auxiliary to the South Carolina Medical Association, Mrs. David F. Adcock of Columbia.

Mrs. Adcock greeted each member, then paid tribute to one of our advisors, the late Dr. James Mc-Leod. Mrs. Adcock, in her charming way, spoke of Auxiliary work, past and present, and urged each one to cooperate to build a larger and better auxiliary. At the close of the talk she was presented a lovely antique cclery tray.

Mrs. Tom Valley served as Santa Claus and from the tree presented each member a gift.

After reciting the creed, the hostess served a delicious salad course, following out the seasonal motif.

PICKENS JANUARY MEETING

The Pickens County Medical Auxiliary met at the home of Mrs. Hal Jamison, Easley, January 8th. Thirteen members were present.

The meeting was opened by the Members repeating in unison the 123rd Psalm and reciting the Lord's Prayer. Mrs. C. E. Ballard, president, called for reports of officers and minutes.

Three baskets were reported sent to needy families at Christmas.

A motion was made and carried that the auxiliary members sponsor picture shows at the high schools on subjects of health as issued by the State Health Department.

A letter was read issuing an invitation to attend a luncheon and tea in Columbia on the 13th, honoring Mrs. Eustace A. Allen of Atlanta, Ga.

Mrs. J. W. Kitchin had charge of the program and read an article "County Doctors Told of State Need of Blue Shield Program." Mrs. Roy Gaston read an article from Cleveland, Ohio, on "Doctors Told of Atom Aid." Mrs. Luke Hamilton's topic was "Medics Honor Dr. William Pressley.

After reciting the Woman's Creed the hostess served a salad course during the social hour.



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- Combined Staff Clinics of the College of Physicians and Surgeons, Columbia University: Am. J. Med. 1:675 (Dec.) 1946.
- 2. Comroe, B. I.: J.A.M.A. 128:848 (July 21) 1945.
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SEARLE RESEARCH IN THE SERVICE OF MEDICINE

COLUMBIA AUXILIARY SPONSORS CONTEST

A campaign for the recruitment of student nurses has been planned by the Columbia Medical Auxiliary. This plan is in line with the request from national auxiliary headquarters to augment the number of student nurses in all schools of nursing in the country. The plan meets with the high approval of superintendents and principals in the high schools, since girls, less frequently than boys, are given help and guidance in choosing careers.

Mrs. W. P. Beckman, chairman of student nurse recruitment for the Columbia Auxiliary, has given a brief outline of the plans. The prospective girl graduates of each senior class in the high schools of Columbia, Richland and Lexington counties will be visited by a graduate nurse who will talk to them on the subject of nursing as a career. Special emphasis will be laid on the reasons for greater demands for graduate nurses today. The opportunities and advantages of nursing will also be discussed.

The Columbia Auxiliary has approved an essay contest in connection with this campaign. First and second prizes will be awarded to winners of an essay on the subject: "Why I Should Like to Become a Student Nurse." Pamphlets and other literature on nursing will be distributed to all girls interested. Posters will be placed in the schools to further stimulate interest.

Mrs. David F. Adcock, president of the Woman's Auxiliary to the South Carilina Medical Association, attended the meeting of the Woman's Auxiliary to the Southern Medical Association held recently in Baltimore. Mrs. Adcock drove to Baltimore with Dr. and Mrs. Vance W. Brabham of Orangeburg. Mrs. Brabham is South Carolina councillor for the Southern Auxiliary. Other South Carolinians attending the convention were Mrs. O. B. Mayer of Columbia and Mrs. C. P. Corn of Greenville.



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VOLUME XLIV

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Number 3

Tetanus: Incidence And Treatment

HENRY C. ROBERTSON, JR., M. D. Charleston, S. C.

Tetanus is a serious disease. It occurs all too frequently despite the availability of practical methods for its prevention. Its mortality continues high despite the use of improved sera and drugs in its treatment. From a review of the records of 76 patients with tetanus in Roper Hospital from 1936-1946, inclusive, we find that there were 43 deaths, a mortality rate of 56.6%. This is more than four times the number of deaths from diptheria in the same hospital during the same period of time.

From a study of clinical features of these cases I wish to bring out certain salient points concerning the incidence, the factors influencing mortality, and the relative effectiveness of various methods of therapy.

INCIDENCE

Of the 76 cases 10 were infants with tetanus neonatorum. Tetanus neonatorum is a fatal disease in this hospital, the 10 cases having a 100% mortality. In the other eases we find that 33 died and that the other 33 recovered, a mortality rate of 50%. The cases of tetanus neonatorum will not figure in the further study of this series. We are concerned solely with the factors relating to the other 66 cases.

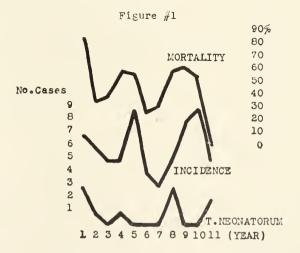
A study of the occurrence of tetanus by the years (see Fig. 1) shows that there is a peak of high incidence at fairly regular intervals, roughly about every 4 years. Similarly if we plot the percentage mortality by years we find that the mortality rate is highest in those years which have the highest incidence of occurrence. Finally, if we plot the incidence of tetanus neonatorum year by year we find that the peak years correspond roughly with the peak years in the percentage mortality and the incidence curves. As a result of this phenomenom we find good tetanus years and bad tetanus years. In the bad tetanus years we find a high ineidence, a high percentage of mortality, and a relative increase in the incidence of tetanus neonatorum. These facts suggest that there may be some hitherto unsuspected periodic change in the life cycle of the tetanus organism. I do not know of any practical value to which this information may be put.

In this series the highest mortality occurred on the third, fourth, and fifth days, although there was no significant drop in mortality until after the eighth day of the disease.

As might be expected the mortality increases with age, running from 35-50% under 15 years of age, and increasing gradually thereafter.

The mortality in this series was roughly inversely proportional to the length of the incubation period. The mortality in those patients with incubation period of 10 days or less was 52%, in those whose incubation period was more than 10 days, 28.5%. The incubation period was known in 50 cases.

Another factor which influenced the prognosis was the length of time which elapsed between the onset of the first symptoms and the development of general spasms. In general, the development of general spasms in a short time after the first symptoms meant a severe, rapidly developing infection, and the mortality



RELATION OF MORTALITY, INCIDENCE,
AND TETANUS NEONATORUM.

in these cases was correspondingly high. Those patients who developed general spasms within 2 days or less after onset of symptoms had a mortality of 68%. Those whose general spasms developed after 2 days after onset of initial symptoms had a mortality of 25.8%. Roughly then, the length of the incubation period and the length of time from the onset of symptoms to the development of general spasms gives us an indication of the severity we may expect in any individual case.

TYPES OF WOUNDS

The injuries which were presumably the ports of entry in these cases are tabulated in Figure 2. The majority of these injuries were of such a nature that many physicians would feel it essential to give passive immunization with tetanus antitoxin, or a booster injection of tetanus toxoid to cases previously immunized. Therefore, theoretically most of these cases could have been prevented by active or passive immunization.

TYPES OF WOUNDS OF ENTRANCE OF TETANUS:

PUNCTURE WOUNDS(Nails, splinters, etc.)	27
LACERATIONS, OPEN	11 5
LACERATIONS, SUTURED	4 2
CRUSHING WOUNDS	2
OLD OSTEOMYELITIS UNKNOWN PORT OF ENTRY	1
TOTAL	66
TOTAL	00

Figure #2

Of the 66 cases in this series there were 15 who had been seen by a physician at the time of injury. Of these 15, 11 were not given tetanus antitoxin or toxoid. Of these 11, 6 patients subsequently died of tetanus. These injuries are listed in Figure 3. These 11 cases represent 16.6% of the total series. This point is not made in any spirit of criticism but in hopes that it will stimulate us not to neglect this important aspect of the treatment of transactic injuries.

The following 4 tetanus patients had been seen by a physician at the time of injury and given tetanus antitoxin as indicated:

- I. Compound fracture, foot-1500 units-mild case.
- 2. Crushing injury, toe-1500 units-severe case.
- 3. Compound fracture, femur-3000 units-mild case.
- 4. Compound fracture, tibia-1500 units-mild case.

All these patients recovered. It will be noted that these injuries were all such that considerable devitalization of tissues was present. It is well to remember that in such injuries 1500 units of antitoxin are generally deemed to be inadequate, and that since passive immunity lasts but 7-14 days, prophylactic tetanus antitoxin should be repeated at weekly intervals at least once in this type of injury.4

PATIENTS PREVIOUSLY SEEN BY PHYSICIAN AND GIVEN NO TRYANUS ANTITOXIN

1. SPLINTER IN FOOT	
2. LACERATION RT. KNEE, SUTURED	DIED
3. LACERATION LEG, SUTURED	
4. LACERATION RT. KNEE, GLASS, SUTURED	
5. LACERATION KNEE, SUTURED	DIED
6. PUNCTURE WOUND, FOOT, NAIL	DIED
7. INFECTED BURNS, RT. ARM	DIED
8. LACERATION KNEE, ROCK	
9. LACERATION RT. FOOT	
10. THIRD DEGREE BURNS, HEAD AND NECK	DIED*
11. COMPOUND FRACTURE, TIBIA	DIED
TOTAL DEATHS	6

*CAUSE OF DEATH: TETANUS AND PNEUMONIA.
Figure #3

LABORATORY WORK

Laboratory findings offered no great aid as an index to prognosis. There were 18 patients who had spinal fluid examinations. In all of them the spinal fluid was normal. However, two of these patients showed marked pleocytosis in examinations repeated after intrathecal administration of antitoxin.

The total and differential leukocyte counts were not really sufficiently indicative to merit more than a mention. The 16 cases whose total white count was over 15,000 had 75% mortality as compared with 50% for the total series. Those patients who recovered averaged 73% polymorphonuclear cells, fatal cases 83%. I doubt if these findings would be of any significance in an individual case.

AUTOPSY FINDINGS

Post mortem examinations were made on 13 cases with the following findings:

Broncho-pneumonia9	cases.
Chemical meningitis2	cases.
Petechial hemorrhage of the brain1	ease.
No significant findings1	case.

It should be mentioned that the duration of the disease in the 9 patients in whom broncho-pneumonia was found at autopsy was from 5-6 days. The two cases with chemical meningitis had been given intrathecal injections of tetanus antitoxin.

EVALUATION OF THERAPY

The cure of tetanus rests on a therapeutic tripod the legs of which are: (1) adequate and early administration of antitoxin; (2) maintenance of sedation; (3) adequate supportive measures to maintain ealoric, protein, electrolyte and fluid requirements.

In evaluating the results of any form of therapy, there is an additional and extremely important fact which must be considered, namely, that there is a great variation in the clinical course of tetanus, from the very severe to the very mild cases. The outcome of tetanus, whether treated or untreated, depends in large measure, on the degree of severity of the disease. For this reason, most statistical studies of large num-

bers of cases have not been particularly useful in evaluating the results produced by various methods of treatment

In an effort to exclude this extremely variable factor, Pratt, in 1945, suggested a method of analysis and classification of cases which promises to be most valuable in determining the results of treatment in any series of cases. He classified his patients in order of severity according to the following criteria:

- I. The incubation period.
- 2. The length of time from the onset of symptoms to definite episodes of generalized muscle spasms, i.e., the invasion period.
- The severity of the infection as judged by examination of the patient at the time of admission to the hospital.
- 4. The frequency and severity of spasms or convulsions after sedation, and the amount of sedation required each day.

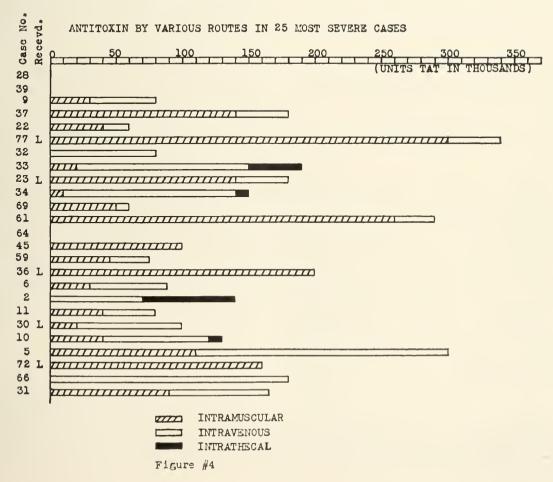
With these as a yard stick, cases may be arranged in series in order of severity, and in this way comparison of results of therapy in similar groups of cases may be of some value. Only in this way may we intelligently ascertain why certain patients in the most severe group survived, and why certain patients with mild tetanus died.

An attempt has been made to follow Pratt's method in the present series. The 66 cases were graded according to the above criteria, then after an interval of three months were graded again. While there was inevitably an occasional change of relative position in the series, rather remarkably the three groups (severe, moderately severe and mild) remained identical. That is, no case moved out of its original grouping.

There were 25 cases of severe tetanus with 20 deaths, a mortality rate of 80%; 21 cases of moderately severe tetanus with 11 deaths, a mortality rate of 53%; and 20 cases of mild tetanus with 1 death, a mortality rate of 5%.

AMOUNT AND ROUTE OF ADMINISTRATION OF TETANUS ANTITOXIN

The antitoxin administered to the 25 most severe cases is shown in Figure 4. The 5 cases who survived are indicated by the letter L on the left margin. The first 2 patients were admitted in the late stages of fulminating tetanus and died before any antitoxin was given. Case #64, thirteenth in order of severity, was given penicillin intrathecally, into the area around the

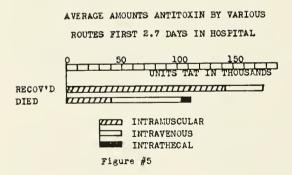


SEDATION

NO. OF CASES

wound of entry, and 330,000 units intramuscularly, but no antitoxin. It will be noted that 4 patients reeeived tetanus antitoxin intrathecally, and that all four of these patients died.

Inasmuch as the hospital stay of the 5 patients who survived averaged 30 days, whereas that of the deaths averaged 2.7 days, the average amount of antitoxin given the survivors was of course greater than that given to the deaths. A comparison of the total amounts of antitoxin given the two groups is not therefore a fair eomparison. A true evaluation should include the therapy given the survivors only during the first 2.7 days after admission. These results (i.e., the averages of the patients listed in Figure 4) are shown in Figure 5. The survivors received a total of 176,000 units of antitoxin, the deaths 104,900 units. Even more significant, however, is the fact that the survivors received 142,000 units of antitoxin intramuseularly, the deaths but 40.250 units. This is in agreement with a recent publication of Silverthorne² who concludes that the intramuscular route is to be preferred to either intravenous or intratheeal routes and should be used exclusively. From the results in the present series it must be concluded that 150,000 units of antitoxin should be given intramuscularly during the 60 hours following admission to the hospital.



There is nothing conclusive in the literature to support the contention that intrathecal administration of antitoxin is more effective than an equivalent amount of antitoxin given by some other route. There is considerable evidence to show that it may sometimes bring about or hasten a fatal outcome. None of the five cases given antitoxin intrathecally in this series survived. Two of these came to autopsy, where an intense chemical meningitis was found. One of these represented the only fatality in the group classified as mild tetanus, and the chemical meningitis was at least a contributing, if not the principle, cause of death. The conclusion is inevitable that the intrathecal administration of antitoxin is unsound and probably dangerous.²

SEDATION

The various types of sedation employed, and the frequency in which used, are shown in Figure 6. The important point is to use that drug or combination of

TYPES OF SEDATION USED.

MAG SULPH I-M OR I-V		20
PARALDEHYDE, BY MOUTH OR RECTUM		16
SODIUM AMYTAL, I-M OR I-V		15
AVERTIN		11
SODIUM BROMIDE AND/OR CHL. HYDRAT.	E P.O.	10
BARBITURATES BY MOUTH		9
MORPHINE		5 5
CALCIUM I-M		5
CURARE, (I-M 2, I-V 2)		4 3
PROSTIGMINE		3
CHLORAL HYDRATE BY RECTUM		2
CHLOROFORM INHALATIONS		1
PARALDEHYDE I-V		1
DEMEROL		1
PENTOTHAL SODIUM		1

Figure #6

drugs which will produce relaxation of muscles and terminate convulsions. A method which will be adequate for one patient will fall far short of the goal in another. In general, however, the most satisfactory results in this series were with Na-amytal intramuseularly and intravenously, and the use of avertin (tribromethanol with amylene hydrate) by rectum. In case #77, which was the most severe case to reeover, avertin was used 18 times, the only untoward effect being a mild chemical proctitis and colitis after 15 instillations had been given. This patient was a 9 year old boy whose generalized convulsions continued for 10 days after admission. Na-amytal intravenously gave him partial relaxation for 15-30 minutes, where as the avertin produced a relaxation which lasted from 3-10 hours.

A word about curare. This drug was used in two cases intramuscularly and in two intravenously. The difficulty in the administration of eurare is the extremely narrow margin between the relaxing dose and the paralyzing dose. One of these patients, given curare intramuseularly, received artificial respiration ten times; another was placed in a respirator. The drug is better controlled when given intravenously, and the antidote (prostigmine) should be kept ready at all times for immediate administration. While it would seem from the results in these cases that better and safer means of sedation are available, a great deal of more recent work has been done on curare, and it bids fair to take a more important part in the therapy of tetanus. Recently myanesin, a synthetic propane derivative, has been used in England. It is said to be more effective than curare and has a wider margin of safety.3

SURGICAL TREATMENT OF WOUND OF ENTRY

There is nothing in this series of cases to indicate that the prognosis was in any way altered by either incision or excision of the wound which acted as the port of entry for the tetanus bacillus. Nearly all published reports of the last few years agree that exeision of the wound is futile, and that in a few

instances patients were worse after this procedure.1, 2 In this series the wounds of 19 patients were excised, of whom 11, or 58%, died. The wounds of 14 patients were incised and drained, of whom 7, or 50%, died. Of the five survivors of severe tetanus, two had incision, one excision, and the remaining two no surgical interference.

It must be inferred, therefore, that while proper surgical care of any injury is essential, surgical intervention is not indicated simply because the wound is the focus of dissemination of the tetanus toxin.

PENICILLIN

There is some evidence to the effect that while penicillin is bacteriostatic, it is not bacteriocidal, to the tetanus bacillus. It has been even more clearly shown that penicillin is ineffective in the prevention or treatment of uncomplicated tetanus. However, as pneumonia is frequently the cause of death in patients who live past the first two days of the disease, the routine administration of penicillin is certainly advisable. It should be given in large doses at 8-10 hour intervals so that the patient will be disturbed as infrequently as possible.

SUMMARY AND CONCLUSIONS

1. Incidence of tetanus occurring in a general hospital over a period of 11 years has been discussed and an attempt made to evaluate the comparative effectiveness of various types of therapy.

- 2. Sheet anchors of effective treatment are: (a) Prompt and adequate administration of antitoxin given intramuscularly, preferably 150,000 units in the first 60 hours after admission to the hospital; (b) Adequate sedation suited to the individual case; (c) General supportive measures; routine use of penicillin for prevention of pneumonia is a necessary adjunct.
- 3. Intrathecal antitoxin is of no apparent value and may be harmful.
- 4. Surgical intervention at the wound of entry is not indicated in treatment of tetanus per se, although the principles which govern the management of any wound should be applied, as with any injury.
- 5. A significant number of cases (16.6%) of this series was seen by a physician at the time of injury, and no prophylaxis against tetanus was given. This finding should serve as a stimulus to all who practice medicine to avoid neglect of this important part of the treatment of traumatic injuries.

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The Human Pyramidal Tract. XVII

A. M. LASSEK, M.D.

The development of motor symptoms in selected cases with complete unilateral destruction of neurons.

The purpose of the present investigation is to correlate the recorded signs and motor deficits in sixteen cases where complete unilateral destruction of the pyramidal tract from cerebral vascular and tumor lesions was found post mortem.

Voluntary motor paralysis is the most common symptom resulting from lesions of the central nervous system in man. The great motor bundle, the pyramidal tract, has long been implicated as being the main or only portion involved in such paralytic conditions. However, the exact role of this bundle in clinical medicine has not been settled to the satisfaction of all neurologists and it appears from recent investigations that it may be more complex than previously thought.

Few pathological studies confined directly to the pyramidal tract have been reported in modern times. It may be assumed that it is not completely destroyed in every case of voluntary motor paralysis. Complete destruction of all neurons is probably relatively rare. In a series of paralytic cases approaching five hundred in number, I have found only sixteen with total or nearly complete degeneration of the component axis cylinders in the pyramids where the tract is completely unmixed with other ascending or descending fibers. An extensive examination of the literature on the pyramidal tract over a period of years has not

revealed any report which discusses the motor signs and symptoms in cases where there is a known loss of all fibers from cerebral lesions.

MATERIAL AND METHODS

The medulla oblongatas and clinical histories of sixteen cases were collected from three New York hospitals. Neurological Institute of New York, Mount Sinai and Montefiori through the courtesy of Doctors Abner Wolf, Joseph Globus and Charles Davison respectively. Nine of the individuals were males and seven females. The average age for the series was forty-seven years. The cerebral pathological lesions consisted of seven cases with unilateral tumors and nine with vascular disease. The duration of motor symptoms for those in the tumor series was thirteen months and for the vascular group, fifty-six months.

Sections of the medulla oblongata of each of these individuals were subjected to Davenport's and Bodian's silver methods and the pyramids examined for the degree of destruction present. Each pyramidal tract was measured by means of a projection apparatus to determine the amount of shrinkage which had occurred as a result of gliosis.

RESULTS

The pathological lesions in the sixteen cases were

TABLE 1

The Sex, Age, Duration of Motor Symptoms, Cerebral Pathology and Percentage of Shrinkage of Pyramidal Tract in Sixteen Cases with Complete Destruction of Neurons.

			Duration of Symptoms in		Percentage of Shrinkage of
Case	Sex	Age	Months	Pathology	Pyramidal Tract
1	M	34	28	Tumor	6.7
2	M	30	6	Tumor	9.1
3	M	43	12	Tumor	10.0
4	F	46	2	Encephalomalacia	10.2
5	M	57	4	Tumor	11.4
6	M	70	7	Encephalomalacia	16.3
7	M	47	18	Tumor	16.8
8	F	50	10	Encephalomalacia	17.7
9	F	65	60	Encephalomalacia	21.8
10	F	57	13	Encephalomalacia	23.2
11	M	57	132	Encephalomalacia	29.6
12	M	49	16	Tumor	33.1
13	M	6	$6\frac{1}{2}$	Tumor	39.0
14	F	62	36	Encephalomalacia	41.2
15	\mathbf{F}	67	132	Encephalomalacia	70.7
16	F	54	108	Encephalomalacia	71.3
Average ch	rinkage in tur	nor caries	18.0		

Average shrinkage in tumor series ______3.6 Average shrinkage in vascular series ______3.6

rather widespread. The minimum extent of the injuries involved parts of the frontal and parietal lobes together, whereas most extended from two or more cerebral lobes into the subcortical regions frequently involving the internal capsule, the basal ganglia and the thalamus. Atrophy of the frontal lobe was present in one case.

Upon examination of the pyramids, all affected tracts were found to show complete or near complete loss of fibers and some shrinkage due to gliosis. The amount of decrease in area, however, varied considerably and could not always be correlated with the duration of motor symptoms. The sex, duration of motor deficit, the cerebral pathology and the amount of shrinkage for each of the involved tracts are given in Table 1. The duration of the motor symptoms varied from fifty-three days to eleven years whereas the shrinkage varied from 6.7 to 88.9%. More decrease in area of the pyramidal tract was encountered in the vascular series, the average ratio of shrinkage being 33.6 to 18.0%.

The reported pyramidal signs and symptoms are given in Table 2. They are as follows: spasticity, 10 cases; absent abdominal reflexes, 7; Babinski or other toe reflexes, 15; hyperactive reflexes, 12; hyperactive reflexes, 3; ankle colonus, 6; and paralyses varying from the milder hemiparesis to the more complete hemiplegia.

TABLE 2

The Reported Signs and Symptoms in Sixteen Cases with Complete Destruction of Neurons.

Hemiparesis	7
Hemiplegia	
Paralysis	2
Dragging leg	1
Pyramidal tract signs	1
Mixed paralysis and paresis in two	
extremities	1
Babinski sign	15
Hyperactive tendon reflexes	
Spasticity	
Absent abdominal reflexes	7
Ankle clonus	6
Hypoactive tendon reflexes	

Although both vascular and tumor lesions may produce similar motor deficits in the end, the mode of onset and course of the symptomatology are entirely different. The loss of the power of movement in the tumor series begins insidiously and gradually becomes more pronounced over a period of months up to one year or more on the average. The initial symptom may be spasms in certain muscles which later become paralyzed. In one individual with a cerebral tumor, the motor symptoms began with dropping of objects and slight dragging of the leg and progressed to an almost total hemiplegia in seven weeks. All of the others advanced much more slowly. In some instances, individuals with cerebral tumors in the series were

subjected to surgical operation and when this was the case it was difficult to correlate the symptomatology which later developed. The mean survival period is only about one-fourth as long in the tumor as in the vascular series, the average being thirteen months with variations from four to twenty-eight.

In contrast, the motor symptoms in vascular lesions which eventually cause complete destruction of the pyramidal tract usually begin dramatically and may cause maximal symptoms from the beginning. These may be followed by regression and sometimes rapid recovery. It is possible to have two or more successive eerebral vascular episodes affecting the same side and it is interesting to speculate as to what damage was inflicted on the pyramidal tract on each occasion. In spite of the fact that vascular injury to the brain may be more damaging to the pyramidal tract initially and as great finally, the patients in this series had a better prognosis surviving four times longer than those with tumors. The survival time varied from fifty-three days to eleven years, the average being four and one-half years. The patho-physiology therefore develops somewhat differently in the two types of lesions and it appears that it is the repeated vascular insult which eventually carries off the patient by damage possibly to vital centers.

COMMENTS

As far as I have been able to determine from a study of the literature, no report has been made of the development of signs and symptoms in human cases where the pyramidal tract has been known to be completely destroyed. How frequently this bundle is entirely degenerated is difficult to say. Many individuals who succumb while in a state of chronic paralysis never come to autopsy because they may not be hospitalized at the time. The pyramidal tract of autopsied cases may likewise not be examined specifically for fiber loss. Since degeneration of all neurons of the great motor bundle should give maximal paralysis, especially when the cerebral lesions are extensive and because of the rarity of suitable specimens, it was felt that an initial study of sixteen available cases might be of some value.

In 1914, von Monakow made the statement that, in his opinion, it requires widespread destruction of the cerebral cortex and possibly the underlying structures to cause complete destruction of the pyramidal tract. It may be more than a coincidence, therefore, that all the cases in the present series had relatively widespread lesions involving more than one lobe and usually the underlying capsule and basal ganglia.

The degree of shrinkage in the affected pyramidal tracts should give a criteria of the duration and initial severity of the neuronal degenerative phenomena. In general, the shrinkage was greater in the vascular group but the individuals also survived longer. It is possible to have a minimal shrinkage in cases of ecrebral tumors preducing motor symptoms lasting over two years duration. The results suggest that

either the speed of shrinkage varies considerably from individual to individual or that some pyramidal neurons may have a latent response to pathological influences in the cerebrum.

Hyperactive reflexes are described as a characteristic sign of pyramidal involvement but in three cases of the series hypoactive reflexes were found in individuals who had motor symptoms for periods of four, six and one-half and thirteen months. The first two of these were tumor cases whereas the third was cerebrovascular. In these individuals, the pathophysiology appears to have been such that inhibition of the motor cells of the spinal cord was permanently produced.

The most popular diagnostic test used in the series was the status of the big toc pathological reflex. The Babinski, or other extensor signs, were reported in fifteen of the sixteen cases reported. In contrast, absent abdominal reflexes were described in seven cases.

It is possible to have complete unilateral destruction of a pyramidal tract producing variable motor deficits diagnosed as follows: hemiparesis, hemiplegia, spastic hemiplegia in flexion and dragging of leg. Some recovery of function can apparently occur when pyramidal neurons are completely destroyed changing the motor picture from a complete hemiplegia to a hemiparesis. It is also possible to have repeated vascular insults on one side each of which causes a more severe and enduring paralysis. In these instances, it must be assumed that either the successive apoplectic attacks affect more neurons of the pyramidal system or other extra pyramidal structures become involved.

The patho-physiology develops somewhat differently in cerebral tumor and vascular lesions. Motor deficit tends to develop gradually and to progressively increase in tumors whereas in vascular accidents the muscular symptoms may appear maximally and then eventually recover to variable degrees. Death is not caused by complete destruction of the pyramidal tract but by other factors possibly in relation to the vital centers or from secondary infections.

CONCLUSIONS

- 1. In sixteen human cases having complete degeneration of the pyramidal tract, the cerebral lesions were all relatively widespread.
- 2. The shrinkage in the pyramidal area varied considerably and could not be correlated with the duration of motor symptoms.
- 3. The motor deficits were somewhat variable being diagnosed as hemiparesis, hemiplegia, dragging of leg and spastic hemiplegia in flexion.
- 4. Hypoactive instead of hyperactive reflexes were reported in three cases with chronic paralysis up to thirteen months.
- 5. The survival period in the tumor series was less than in the vascular group.
- 6. The motor deficits become progressively more severe in the cases with cerebral tumors whereas regression and recovery may occur in those with cerebrovascular lesions.
- 7. In pyramidal tracts showing complete loss of fibers post mortem, repeated vascular insults to the brain can occur each of which may cause added motor deficits.

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FOOTNOTE

- 1. This study was aided by a grant from the Committee on Scientific Research of the American Medical Association.
- 2. All of the technical work was performed by Miss Margaret M. Powers, technician.

What's New

Following the eight minute discussion of the newer developments in their particular fields by the "experts" at the annual meeting last May, opportunity was afforded for the asking and answering of questions.

Now that all of the discussions have been published, we herewith present the questions and answers.

-Editor

OTOLARYNGOLOGY

DR. R. MacDONALD:

Question 1—Discuss the value of Rutin in hemorrhagic states?

Answer—I regret to say that as far as I know the use of Rutin is still in experimental stages. There is a good deal of information appearing in the literature and Dr. Gibbes discussed it.

Question 2—Discuss treatment of earaches due to aeroplane rides without rupture drums.

Answer—Complete rest for patient, aeration of nasopharynx, and use of eustachian catheters. Gently inflate the middle ear. In addition to that I believe most of us would be surprised at the number of times, in adults, we find lymphoid tissue present. In order to prevent future occurrence, it is necessary to eliminate that lymphoid tissue from the naso-pharynx. In my paper I touched on the point that radium applications were most successful. This treatment is very satisfactory, the only thing is the initial cost of the radium.

CHEMOTHERAPHY

DR. J. H. GIBBES:

Question 1—How long should treatment with gold therapy in rheumatoid arthritis be given before results are to be noted?

Answer—I really don't know but certainly it is a matter of months. The reaction to gold therapy is a slow process. In that connection it is interesting that if the patient is to show toxic reactions they will appear fairly early in the program and as the therapy goes on you can continue its use with more and more assurance that the toxic manifestations of the drug will not appear. It is a long continued process, as you know. In my opinion it will be months before you will expect to see favorable results, then the treatment is maintained on a basic foundation over a period of years. It is utterly indefinite.

Question 2—Discuss the time interval between doses of penicillin and streptomycin?

Answer—That, I think, brings us again into the relatively unknown field with reference to the development of therapeutic efficiency and modes of optimum application of these relatively new agents. Theoretically, in considering the use of antibiotics in

contrast to bacteriocidal substances, the conception is that we should strive to maintain a blood level of the antibiotic at an optimum point to discourage the growth of the organism we are concerned with. To accomplish this these drugs have been given at frequent intervals. There is a variation developing today in this time interval with the idea of serving the convenience of the patient and physician, for example, in giving penicillin. This has been facilitated by the development of the penicillin in wax and oil. In some instances the penicillin is found to give satisfactory results when given at 12 hour intervals in doses of 100,000 units.

Streptomyein,—the idea has been advanced that it may be advantageous to produce relatively high blood levels and then permit them to drop so that the organism doesn't become resistant to the drug.

I feel, and hope you do too, that we are still in the experimental field in the development of these new agents and will know more about them as time goes on.

GASTRO-ENTEROLOGY

DR. HUGH SMITH:

Question—How much importance do you attach to gastric analysis outside of the finding of achlorhydria?

Answer—I would say no other significance. My only interest is whether HCL is present. If absent in the first specimen, we do a serial analysis after histamine. If present in the first specimen, we discontinue the analysis then.

DERMATOLOGY

DR. JOHN VAN de ERVE:

Question 1—Treatment of Contact Dermatitis of evelids?

Answer—In contact dermatitis of the eyelids we take away the nail polish and put it on the chest for 48 hours. If it is found responsible, we take it away for six months. I have a cream that I have found very useful: 10% Phemerol Topical in cold cream.

Question 2—Treatment of infectious eczamatoid dermatitis of ears?

Answer—As to the dermatitis of the ears, since many of these are due to a yeast infection, as well as to staphylococci, I wash the ear thoroughly with peroxide (full strength) three times daily and paint or swab with 1% gentian violet (aqueous).

Question 3—Does the intravaginal application of sulphonamide in creams have the same risk at its skin application?

Answer—I think so. The main difference is that you get more surface absorption to sensitize, and about the same risk of topical irritation.

CARDIOLOGY

DR. SOL ZIMMERMAN:

Question 1—What is your opinion of the direct writing E.K.G?

Answer-I have no experience with it whatsoever.

Question 2—What is the treatment of heart block with Stokes-Adams syndrome in acute coronary thrombosis?

Answer—I might state that despite the relative frequency of complete AV dissociation following occlusion of the posterior right coronary artery, the incidence of the Stoker—Adams syndrome is infrequent. This is probably due to the fact that most of these patients die before they are seen by the physician. In the event that such a case is under observation during the reestablishment of the atsioventricular rhythm and with the manifestation of syncope, the patient should be placed flat in bed; given oxygen under high concentration; large doses of atropine; and an abdominal binder. The situation is not intrequently relieved either spontaneously or as a result of the therapy. If it continually occurs, some thought should be given to the careful use of adrenalin.

PEDIATRICS

DR. R. M. POLLITZER: I have several questions here:

Question I—Should a child with infantile eczema be immunized against pertussis, diptheria, etc.? When should this be done?

Answer—Yes. There is no contra-indication to the use of toxins, toxoids or vaccines because of an eczena. Further, not to inmunize is too great a risk. Immunizing, in my opinion, should be done at about 6 months. However, although we do not always adhere to the rule, we advise smallpox vaccination between the ages of 3 and 6 months, unless there is a definite reason for postponement.

Question 2—If, in giving the final immunization dose of the combination diptheria, tetanus and pertussis toxoid, an abscess develops, is there any need in repeating any of the last dose, (i.e., after the abscess has been drained)?

Answer—Yes, if there is any question of the absorption of the immunizing dose it should be repeated. However, unlike some, I do not routinely use Diphtheria, Tetanus, Pertussis Alum Precipitated Toxoid eombined. For I have seen some very bad local reactions. I prefer to use the Pertussis Toxoid separately in 3 doses. It is my custom to use the Diphtheria Tetanus Alum Precipitated Toxoid in two doses. It is extremely rare that the injection eauses much redness or swelling.

Question 3—Value of streptomycin in whooping cough versus pertussis endotoxoid used in treatment?

Answer—I haven't used streptomycin in whooping cough, although I am well aware that some have. Formerly I used various injections with the hope of decreasing the spasms and shortening the duration of

the illness. But within the past year I have had such surprisingly good results with Cutters Anti-Pertussis Serum (human) that I am not willing to try anything else. Among the cases that have been so treated are infants of 6 weeks, 3 months and 6 months, as well as older children. I am so well pleased that I hesitate to change. However, I may of course, be of a different opinion later.

Question 4-4s there any new treatment reported in blood dyscrasias, such as leukemias?

Answer—At present there is much work being done with radio active substances, particularly phosophorus and iodine, in blood dyserasias. The investigation seems to be promising already, and may in the future give us something worthwhile against leukemia. But we haven't anything at all now that is effective.

Question 5—Say something about exsanguination transfusions in the RH factor problem?

Answer—Exsanguination transfusion is of course the ideal treatment. It is dramatic, quick and done with brilliant results. Several such cases are in the literature, but I, myself, have not had any experience with this technique.

ORTHOPEDICS

DR. 1. A. SIEGLING, Charleston:

Question I—What is the best present preparation of the skin to prevent an operative infection in a clean case?

Answer-This is a moot question because you will find clinics in various parts of the country use different preparation. I believe in a thorough washing of the skin the night before the operation. The patient comes in the day before; the evening before the operation the skin is scrubbed with soap and water to get dirt and grime out of the pores. It is an important thing to postpone surgical preparation of the skin until the morning of the operation—in the shaving process, small nicks are made in the skin which gives an opportunity for bacterial contamination if the wound stayed open during the night. The next morning you have a surgical wound of ten hours duration in which bacteria have had a chance to thrive. The surgical shaving is done in the morning; scrubbed again with soap and water and wrapped in a sterile towel at the time. Preoperatively we use alcohol followed by ether to get off the fatty material followed by any one of the bactericidal solutions. We use merthiolate and like it. I do feel the important thing is to scrub the skin the night before and don't shave the skin until the morning of the operation,

Question 2—What is the status of streptomycin in orthopedic work? What about streptomycin in treatment of bone and joint TB?

Answer—I feel that in bone and joint tuberculosis its status is about the same as in pulmonary tuberculosis. I still think it requires a great deal of study and I have not used it. It will require a great deal of clinical work to truly decide its efficacy.

Question 3—What is your feeling in orthopedic work concerning the recent trend toward early ambulation following surgery?

Answer—I am entirely in accord with early ambulation if it doesn't interfere with certain principles. Fractures of hip and spine and ankle and fractures of elderly people definitely should get up early. In midshaft fractures of the femur I do not feel it is so important in trying to get them up early or in using a number of types of splints and sacrificing certain things. Certain fractures still require a protracted period of bed rest and the femoral shaft fracture is one of those.

Question 4—What is the stage of acceptance of Ransohoff's plan of treatment of acute poliomyelitis with curare?

Answer—That is highly experimental and will not reach general acceptance as a method of treatment of infantile paralysis. The anti-spasmodies have been used—I think they too will pass. I have not noticed any definite help from them.

Question 5—Do you feel that treatment of low back pain is generally of adequate duration? What period of time do you consider adequate?

Answer-I feel we are prone to operate on spines as a whole too early. Many spines have a functional capacity for work and it is important to instill in the patient the realization they have a limited functional capacity. Where a patient is incapacitated because of back pain, operation is indicated if a definite lesion is there to be helped. Incapacitation over a number of months with a ruptured disc and failure of conservative measures and bed rest, would indicate surgical interference. In ordinary back pain, where a suspected lumbosacral lesion exists, it is best to carry the patient over months or a year or so, and then to major surgery. I feel the treatment of backache is largely conservative and surgical treatment is indicated where there is definite incapacity over a period of months and at times even a year.

SURGERY

HORACE G. SMITHY, M. D.:

Question 1—Will you please differentiate phlebothrombosis and thrombophlebitis and give the care of each?

Question 2—Do you advocate anti-coagulants in the treatment of phlebothrombosis?

Answer—I believe these two questions can be answered simultaneously. To differentiate between phlebothrombosis and thrombophlebitis, one is obliged to accept the fact that intravenous elotting occurs both with an inflammatory reaction and without an inflammatory reaction. The former is characterized by considerable pain over the distribution of the deep femoral vessel, pressure pain in the ealf, usually some fever, a positive Homans' sign, which is pain on forced dorsillexion of the foot, the pain appearing in the ealf of the leg, and marked

edema of the extremity usually from the knee down but sometimes involving the entire leg. Because of the associated inflammatory reaction, intravascular thrombi in this condition are prone to remain fixed and are, therefore, seldom a source of pulmonary emboli. Undoubtedly, the most effective treatment for acute thrombophlebitis is early interruption of the lumbar sympathetic nerve impulses on the affected side. This can be done most simply by paravertebral injection of novocaine or a longer-lasting local anesthetic such as Eucupin in oil. Such injection therapy should be done daily until there is a pronounced decrease in the size of the extremity and disappearance of the pain and associated inflammatory reaction, all of which occurs usually quite promptly.

Phlebothrombosis, so-called by Ochsner and his coworkers, is the insidious occurrence of thrombosis within the veins usually of the lower leg without an associated inflammatory response. In the absence of inflammation, the signs and symptoms are very mild and frequently not detectable until an episode of nonfatal pulmonary embolism has occurred. We do not advocate the use of anti-coagulants in the treatment of phlebothrombosis. Anti-coagulant therapy is dangerous for obvious reasons, it does not prevent the detachment of a thrombus once clotting has occurred, and finally it is quite expensive. When the diagnosis of phlebothrombosis has become established, or when a non-fatal pulmonary embolism has occurred, we believe that prompt interruption by ligation and division of the affected femoral veins should be done. Occasionally, it may be necessary to ligate either the common iliac veins or possibly even the vena cava depending upon the extent of the intravascular thrombosis.

Question 3—Please discuss briefly the treatment for Buerger's disease?

Answer-Briefly, the treatment of choice in Buerger's disease is surgical removal of the sympathetic ganglia concerned. Sympathectomy decreases or entirely eliminates intermittent claudication, it relieves the severe rest pain, it allows ulcerations to heal and, if amputation becomes inevitable, a lower level can usually be obtained. If the patient's general condition is such that sympathectomy cannot be done, medical therapy should be tried but usually offers very little. The various measures include the oscillating bed, Buerger's exercises, complete abstinence from tobacco, thiamin chloride and nicotinie acid, intermittent suction and pressure such as is obtained by using a Pavaex boot and the intravenous administration of tetraethyl ammonium chloride. The latter drug is new and is not commercially available as yet but shows some promise as being a valuable vasodilator.

Question 4—Does postoperative therapy routinely with Vit. B Complex with ascorbic acid hasten healing and give better results?

Answer—I do not think it is necessary to use Vitamin C routinely in surgical patients. The majority of individuals seen in private practice present an

adequate state of nutrition and, therefore, do not require accessory vitamin therapy. On the other hand, when there is an obvious nutritional lack, such as we so commonly see among our Negroes in Charleston County, intensive vitamin therapy prior to operation will no doubt have a beneficial effect on postoperative wound healing. It is in this group of patients that preoperative administration of Vitamin C will diminish the incidence of postoperative wound disruption.

OBSTETRICS AND GYNECOLOGY

DR. I. D. GUESS:

Question 1—How deep should an episiotomy be? Should the levator muscle be cut?

Answer—The episiotomy should be as deep as is necessary to extract the baby without further tearing of the perineum. A medio-lateral episiotomy is probably the best form of episiotomy at this time, which is a median incision down to the sphincter muscle, or almost, and then turn laterally as far as necessary and that opens up the vaginal orifice very well. The trouble in cutting the sphincter muscle is in repairing it.

Question 2—Advisability of routine checking of prospective parents for RH factor?

Answer—I referred to that in my discussion. Mothers should be routinely checked for RH Factor. If they are RH negative then the husband should be checked. If both are RH negative the baby will be all right. If the mother is RH negative and needs a transfusion she should have a transfusion from a RH negative donor. If she is RH positive, then you need not check the husband at all.

Question 3—What are the more frequent pelvic conditions causing pain in breast?

Answer—Pregnancy first. Practically all complain of this symptom. And, reasoning from that—in pregnancy there is a high blood level of estrogen, just so, any pelvic condition that produces a high blood level of estrogen (particularly where the estrogen is not complemented by progesterone) will likely be accompanied by painful breasts.

Possibly, in non-pregnancy, we see them in these hypersexed girls, with bumps on their faces, small genitalia, etc., they don't have a high estrogen blood level.

Question 4—What treatment would you give in an acute yellow atrophy of liver with patient at term, with uncontrolable hemorrhage?

Answer—If I were a Catholic, I would call the Priest.

Fortunately for us, acute yellow atrophy of the liver is rather rarc. In my experience I have had one definitely to develop that, and I have had a few cases of mild jaundice that may have been mild yellow atrophy, perhaps mild chloroform poisoning. After the Priest had administered the last sacrament I would have gotten prepared to give a blood transfusion and empty the uterus, Cesarean section by local anesthesia, and prepare for the funeral.

Question 5—What is your *present* opinion on caudal anesthesia in OB cases (Labor) . . . ?

Answer—Briefly, in those who know how to use a continuous caudal anesthesia, who work in institutions where the assistants are prepared to assist; in a woman who would like to have caudal anesthesia, or in a woman to whom inhalation anesthesia would be a definite hazard,—swell. You and I, 98% of us in this room, are not prepared to use it ourselves, we do not have the set-up in our hospitals to use it, and most of us had better leave it alone.

Question 6—Present treatment for threatened abortions in first trimester?

Answer—The most important thing is to render the patient inactive. Put her to bed and no bathroom privileges. The second,—a treatment that is proving favorable in the treatment of cancer of the cervix, is to give the patient large doses of progesterone, 10 mg., three times a day. That seems to have been of help on threatened abortion. If pain is present,—the use of morphine.

Remember, one-third of pregnancies tend to end in abortion, and a high percentage of the one-third is a conservative process, getting rid of defective embryos, or because the sperm or something was defective. This method of treating threatened abortions will not prevent the expulsion of the defective sperm. No fear there. On the other hand, it will stop many threats of abortion of normal embryos.

Question 7—Watery discharge from nipple in woman 45 years of age—3 children, youngest 15, no other pathology in breast found. Discuss etiology and treatment.

Answer—In a woman 45 years of age,—the first thing I would think of was pregnancy; that, most frequently, is the cause of a watery secretion from the breasts. The next thing I would think about, in a breast that has lactated,— is that a watery secretion may be expressed in many individuals, perhaps most individuals, for years after lactation. Furthermore, women who have never lactated, at menstrual time develop a watery secretion from their breasts.

If none of those things were present, I don't know what would be the cause and I don't know how I would go about finding out. The characteristic secretion, suggesting malignancy in the breast, if it occurs at all, is a blood-stained secretion, rather than a watery secretion.

ANNUAL FINANCIAL REPORT

SOUTH CAROLINA MEDICAL ASSOCIATION FOR YEAR ENDING DECEMBER 31, 1947 SOUTH CAROLINA MEDICAL ASSOCIATION BALANCE SHEET

December 31, 1947

ASSETS

Petty Cash Guaranty Bank and Trust Company Accounts Receivable Deposits Receivable		\$ 10.00 17,901.96 1,058.41 3.00	
Investments Defense Bonds Peoples Federal and Saving	\$ 6,500.00 5,000.00	11,500.00	
Office Furniture and Fixtures		2,025.56	
Total Assets			\$32,498.93
LIABILITIES			
Social Security Withholding Tax Cuts in Journal		$30.00 \\ 338.40 \\ 14.60$	
Total Liabilities			383.00

SURPLUS

lance January 1, 1947 cess of Revenue over Expense	$24,354.80 \\ 7,761.13$
Total Surplus	32,115.93
Total Liabilities and Surplus	\$32,498.93

We have examined the treasurer's records of the South Carolina Medical Association for the year ended December 31, 1947 and,

We certify that in our opinion the above Balance Sheet and accompanying Statement of Revenue and Expense sets forth the financial condition of the South Carolina Medical Association as at December 31, 1947, and the results of its income and expense for the year ended on that date.

Respectfully submitted,

JAILLETTE & BRUNSON Public Accountants

Florence, S. C. January 22, 1948

SOUTH CAROLINA MEDICAL ASSOCIATION STATEMENT OF REVENUE AND EXPENSE

January 1, 1947 to December 31, 1947

Revenue		
Membership Dues	\$15,367.00	
Subscription Dues	2,772.00	
Advertising	12,153.37	
Interest Earned	162.50	
Miscellaneous Income	1,002.10	
Exhibits	2,424.85	
Gross Revenue		\$33,881.82
Less Expense		
Audit and Legal	85.00	
Convention Expense	2,373.02	
Council Expense	24.00	
Dues and Subscriptions	112.00	
National Conference	598.68	
Heat, Light, Fuel and Water	47.35	
Insurance	12.90	
Miscellaneous	530.19	
Office Supplies	574.63	
Printing	5,472.50	
Rent	531.00	
Salary—Secretary and Editor		
Salary—Secretary and Editor Salary—Director of Public Relation	2,700.00	
	6,000.00	
Salary—Business Manager	1,450.00	
Salary—Stenographer	1,563.50	
Postage	90.00	
Taxes and License	84.60	
Telephone	392.98	
Traveling Expense	42.00	
Bank Charges	3.08	
Centennial Fund	640.75	
Expense—Director of Public Relation	540.85	
Emblems	1,326.15	
Special Study, S. C. State Board of Health	597.60	
Membership Rosters	327.91	
m . 1 D		

Total Expenses Excess of Revenue over Expenses 26,120.69

\$ 7,761.13

The Journal of the South Carolina Medical Association

EDITOR: Julian P. Price		Florence, S. C.
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Please send in promptly notice of change of address, giving both old and new; always state whether the change is temporary or permanent. Original manuscripts, subject to approval by the Editor and the Editorial Board, are desired for publication in the Journal. They should be typewritten, double spaced, on 8½ x 11 paper. References should be complete, and only such as relate directly to statements quoted in the paper. Illustrations will be used as funds permit, or as authors are willing to bear the necessary increase in cost. Short original articles are preferred to long reviews.

Office of Publication: (In care of the Editor) Florence, S. C. Subscription Price \$3.00 per Year

MARCH 1948

PHYSICIAN AND SERVANT

There could be no finer epitaph for a physician than that which was given Dr. William E. Hicks of Sardis by a news reporter. The account of his death which appeared in the recent daily press was concluded with this simple statement, "Dr. Hicks spent his last 38 years as a physician and servant of Florence County at Sardis."

"Physician and servant —Dr. Hicks was just that, and so have been many other of our colleagues who have passed on to their reward. By training these men have been skillful physicians, by choice they have been servants of the people. Desire to help others and not love of money or fame drove them on in their daily and nightly work. The need of the patient—not his social standing or his financial rating—determined their course of action. And their reward was not in treasures upon earth but rather in love in the hearts of those who knew them—and treasures in heaven.

As we have seen these colleagues of ours live and work and die, it gives us a feeling of pride and humility—pride in the fact that they were part of that profession which we claim as our own, humility as we compare the work which we are trying to do and the service which we are endeavoring to give with that which they did and gave.

OCONEE COUNTY

The strength of a state medical association lies in the strength of its component county medical societies. Nowhere has this been better demonstrated than in a recent action of the Oconee County Medical Society.

The members of this society realized the harm which is being done—to the people of South Carolina—by certain individuals who under the guise of being trained in the art of healing are carrying on the practice of medicine. Showing their certificates as graduates of a school of naturopathy or some allied cult, they attempt medical and surgical procedures in which they have had completely inadequate training. And the ones who suffer from this ignorance and mispractice are the people who are gullible enough to fall for their false claims.

The members of the Oconee Society felt that something should be done and that it should start at the county level. They realized that the State Association has been working along the same line, but they also knew that the votes of legislators are primarily determined by the wishes of the "folks back home." So in business session, they drafted the following letter and sent it to their representatives in the General Assembly:

Seneca, South Carolina Ianuary 9, 1948

Senator Lewis Rowland Representative John Knox Representative J. Pat Miley Gentlemen:

At the December meeting of the Oconee County Medical Association the problem caused by the practice of chiropractic and naturopathy in Oconee County and in South Carolina as a whole was discussed.

As we understand it, these men are licensed to practice their vocations within definite restrictions prescribed by the law. It has been brought to our attention that certain members of these vocations are doing the general practice of medicine, prescribing drugs, and so forth for which they have no license. Also certain members have advertised themselves to the public as "physician," thereby misleading the public to believe that they are doctors of medicine, and have in certain instances caused damaging results to the patient.

fn order to correct the above related situation we would like to see legislation of the following nature:

- 1. Law and enforcement of said law requiring these individuals to confine their work to practices allowed by their licenses.
- 2. A more rigid state license law that requires all chiropaths, naturopaths, osteopaths, and allied fields to pass basic science evanuinations before qualifying for license. Other states are stricter than South Carolina in this respect and our laws in this matter need changing.

We, the undersigned members of the Oconee County Medical Association, lope that you will see fit to introduce and press passage of adequate legislation to control the problem presented to you in this letter.

Respectfully submitted,
T. G. Hall, M.D.
J. N. Webb, M.D.
W. A. Strickland, M.D.
L. E. Mays, M.D.
W. C. Mays, M.D.
F. T. Simpson, M.D.
J. E. Orr, M.D.
John T. Davis, M.D.
J. P. Booker, M.D.

If every county society in the state would inform its representatives as the Oconee Society has done concerning its opinions upon pending or necessary legislation, it would be a great thing for the people of South Carolina.

PLANNING FOR HOSPITALS

We have recently received a copy of "The State Plan" for the construction of hospitals and health centers in the state of South Carolina, prepared by the S. C. State Board of Health (in consultation with the State Hospital Advisory Council), and approved by the Surgeon General of the U. S. Public Health Service. This will constitute a blue-print for hospital construction in this state for the next five years and should be carefully studied by anyone who is contemplating the building of a hospital or the expansion of present facilities.

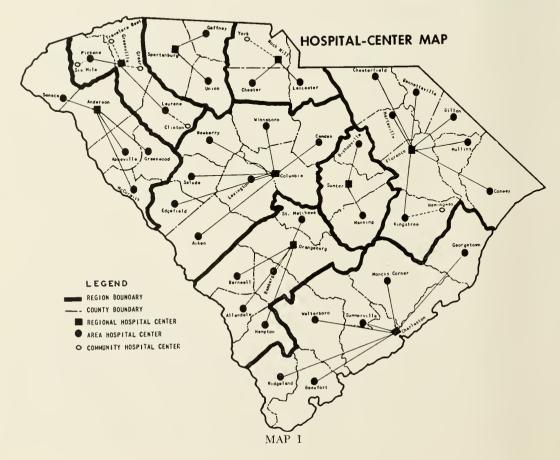
We have been informed that any county medical society may secure a copy of this report for study if desired. The request should be sent to Dr. C. L. Guyton, State Board of Health, Columbia.

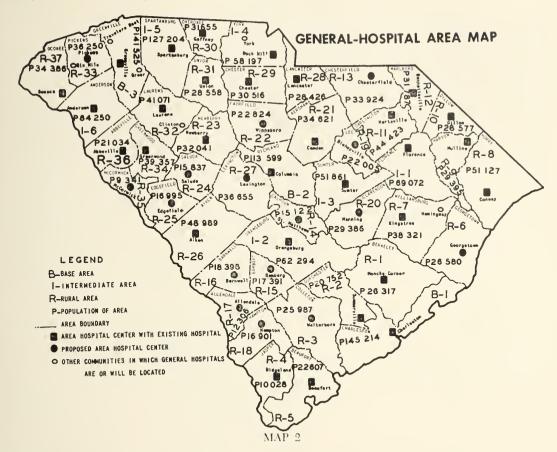
There is a wealth of information in this report as to present conditions and future needs. We wish that it were possible to publish the report in full so that every member of the Association could read it at first hand. Unfortunately this cannot be done so we are presenting herewith certain of the key maps and charts in the hope that this will give at least a slight understanding of what the plan proposes.

Map 1 shows the way in which the state is divided into regions with regional and area hospitals. Map 2 shows the plan in greater detail as to hospitals, population, etc. Each area is designated by a specific number (i.e. I-1, R-2, etc.). The key to these numbers is found in Chart 2. Map 3 shows the proposed public health facilities for South Carolina.

Chart 1 gives a report of the general bed distribution and the additional beds which may be constructed in a given area, under this plan. (Areas referred to in this chart by numbers I-2, R-3, etc., may be determined by referring to Chart 2.)

Under the law, the State Board of Health was not only instructed to set up a plan for hospital construction, but also to establish minimum standards for





maintenance and operation of hospitals in South Carolina. Here are the standards which have been adopted.

MINIMUM STANDARDS FOR MAINTENANCE AND OPERATION OF HOSPITALS IN SOUTH CAROLINA

To provide safe and adequate eare for the sick and injured in all hospitals throughout South Carolina, whether general or highly specialized in nature without regard for size or type. Minimum standards are set forth below:

I. ORGANIZATION

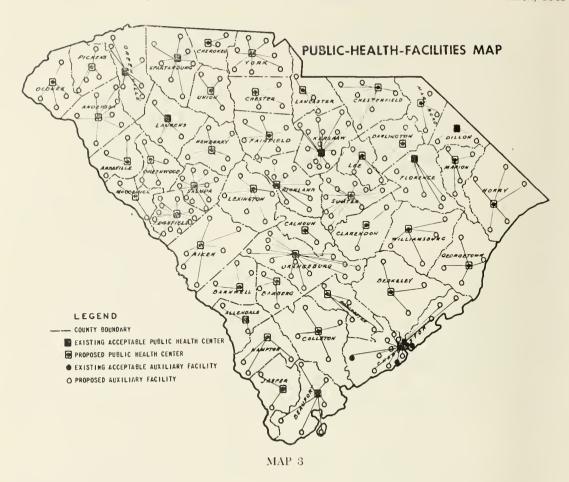
- a. The organization should consist of a supreme governing body qualified to administer a hospital. This may be a board of trustees or directors, earefully selected.
- b. There must be a well qualified executive officer who may be designated as administrator, superintendent or director or by some other title. This person should be responsible to the governing body for carrying out its policies.
- c. The executive officer shall be assisted by competent personnel adequate to the needs of the institution. This personnel shall be properly organized and under competent supervision.

II, PHYSICAL PLANT

- a. The hospital plant shall consist of suitable safe buildings maintained in a sanitary condition, provided with fire protection, preferably fireproofed, and adequately equipped and furnished for the comfort of patients.
- b. Hospitals accepting surgical and obstetric patients shall provide a modernly equipped operating room, a delivery room, and a nursery, all suitably safeguarded.

III. MEDICAL STAFF

- a. Physicians and surgeons priviledged to practice in the hospital shall be organized as a definite medical staff.
- b. Membership upon the medical staff shall be restricted to physicians and surgeons who are
 - Graduates of medicine of approved medical schools with the degree of Doctor of Medicine in good standing and legally licensed to practice in their respective states.
 - (2) Competent in their respective fields and
 - (3) Worthy in character and in matters of professional ethics.
 (In this latter connection the practice of



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	R-3	25,987	13.7	65	0	117	65	52	22	87	87
	R-4	10,028	45	25	25	20	0	20	5	30	5
	R-5	22,607	102	57	42	60	15	45	20	77	35
	R-6	26,580	120	66	0	120	66	54	29	95	95
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1	R-7	38,321	172	96	86	86	1.0	76	25	121	35
N	R-8	51,127	230	128	65	165	63	102	53	7.81	116
28	R-9	29,395	132	73	73	59	o .	59	31	104	31
F	R-10	29,577	129	71	60	69	11	58	25	96	36
	R-11	lılı, 423	200	111	74	126	37	89	49	160	36 86
	R-12	31,787	143	79	74	69	5	64	32	111	37
	R-13	33,924	153	85	0	153	85	68	31	116	116
	n-15	339744	100	V >	0	177	0)	00	ا در ا	. 110	110
ORANGE	BURG REG	ON.									
Oldande	I-2	62,294	280	249	122	158	127	31	62	311	189
	R-14	15,122	68	38	0	68	38	30	13	51	
	R-15		78	43	0	78	43	35	18	61	51 61
		17,391		43	0		43			65	65
	R-16	18,398	83			83		37 2h	19		13
	R-17	12,306	55	31	0	55	31		10	41	111
	R-18	16,901	76	42	0	76	42	34	1/4	56	56

CHART 1

AND		BED ALLOWANCES BASED DII		EXISTING ACCEPTABLE	DETERMINATION OF POOL BEDS			TO ABEA FROM	TO TAL BEDS	MET ADDITIONAL BEDS WHICH MAY BE	
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1	R-24	15,837	71	40	0	71	40	31	12	52	52
29	R-25	16,995	76	42	0	76	42	34	14	56	56
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	R-30	31,655	143	79	48	95	31	6Ŀ	29	108	60
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the division of fees, under any guise whatsoever, shall be prohibited.)

c. The medical staff shall initiate and, with the approval of the governing board of the Hospital, adopt rules, regulations and policies governing the professional work of the hospital.

These rules, regulations and policies shall specifically provide

- (1) That medical staff meetings be held at least once each month.
- (2) That the medical staff review and analyze at regular intervals their clinical experience in the various departments of the hospitals, such as medicine, surgery, obstetrics and the other specialities; that the medical records of patients, free and pay, be the basis for such review and analysis.

IV MEDICAL RECORDS

a. An adequate record system shall be maintained. Accurate and complete medical records shall be written for all patients and filed in an accessible manner in the hospital. The attending physician is directly responsible for the accuracy and completeness of his case records, whether prepared by him or by another. A complete medical record is one which includes identification data; complaint; personal and family history; history of present illness; physical examination; special examination, such as consultations, clinical laboratory, x-rays, and other examinations; provisional or working diagnosis; medical or surgical treatment, gross and microscopical pathological findings; progress notes; final diagnosis, condition on discharge and follow up and in case of death. autopsy findings.

b. Monthly and annual analyses of services to patients shall be made in order to improve services to patients and to keep the service on the highest plane of efficiency.

V. DIAGIOSTIC AND THERAPEUTIC FACILITIES

a. Adequate diagnostic and therapeutic facilities with efficient technical service under competent supervision shall be available for the study, diagnosis and treatment of patients.

VI. ULTIMATE OBJECTIVE

a. The intent and ultimate objective of maintaining standards for hospitals is to establish in the hospital an environment in which every practitioner of medicine can carry on his work in such a manner as will be conducive to accurate diagnoses and efficient treatment in order that every patient who enters the hospital may be returned to normal health and production, if possible, in the shortest time and most comfortable manner.

In brief-to maintain a humanitarian attitude in which the best care of the patient is always the primary consideration.

CHART 2

HOSPITAL AREAS

BY REGIONS

CHARLESTON REGION:

B-1 Charleston

Berklev R-1

Dorchester R-2

R-3 Colleton

R-4 Jasper

R-5 Beaufort

R-6 Georgetown

FLORENCE REGION:

I-6 Florence

Williamsburg R-7

R-8 Horry

R-9 Marion

R-10 Dillon

R-11 Darlington

R-12 Marlboro

R-13 Chesterfield

ORANGEBURG REGION:

I-2 Orangeburg

R-14 Calhoun

R-15 Bamberg

R-16 Barnwell

R-17 Allendale

R-18 Hampton

SUMTER REGION:

I-3 Sumter

R-19 Lee

R-20 Clarendon

COLUMBIA REGION:

B-2 Richland

R-21 Kershaw

R-22 Fairfield

R-23 Newberry

R-24 Saluda

R-25 Edgefield

R-26 Aiken

R-27 Lexington

ROCK HILL REGION:

I-4 York

R-28 Lancaster

R-29 Chester

SPARTANBURG REGION:

I-5 Spartanburg

R-30 Cherokce

R-31 Union

GREENVILLE REGION:

B-3 Greenville

R-32 Laurens

R-33 Pickens

ANDERSON REGION:

I-6 Anderson

R-34 Greenwood

R-35 McCormick

R-36 Abbeville

R-37 Oconee

PRELIMINARY PROCRAM

CENTENNIAL MEETING

MAY 12, 13 and 14

CHARLESTON, S. C.

(Headquarters—Francis Marion Hotel)

WEDNESDAY, MAY 12.

Meeting of Council-Mezzanine Room 10:00 a.m.

2:00 p.m. Meeting of House of Delegates-Ball Room

8:30 p.m.

Dock Street Theater Elmer Rice's play – "Dream Girl"

(Members and wives to be guests of Charleston Society. No seats reserved, Drinks and sandwiches between acts and after show, continuing ad lib.)

THURSDAY, MAY 13. - SCIENTIFIC PROGRAM

9:30 a.m. Invocation

Welcome Address Response–Vice President of S.C.M.A.

10:00 a.m. Addresses by:

Dr. George F. Lull, Secretary, American Medical Association, Chicago, Ill. Dr. Warren W. Quillian, Pediatrician, Coral Gables, Fla.

Dr. I. A. Bigger, Surgeon, Medical College of Virginia, Hospital Division, Richmond,

Virginia.

1:00 p.m. Alumni Luncheon, Francis Marion Hotel

3:00 p.m. Dr. James E. Paullin, Internist, Atlanta, Ga.

Dr. V. K. Hart, Otolaryngologist, The Charlotte Eve, Ear and Throat Hospital, Charlotte,

N. C.

8:00 p.m. Banquet and Ball - Francis Marion Hotel

Toastmaster — Dr. Olin Chamberlain Orchestra — "Bill Abot" Address — Dr. Reginald Fitz, Boston, Mass.

FRIDAY, MAY 14

9:30 a.m. to 12:00 noon-"Recent Advances"

I. Chronic Cardio-Vascular Renal Diseases

Progress in Medical Management—ten minutes

Progress in Surgical Management-ten minutes

2. Chronic Pulmonary Disease

Medical Management-ten minutes

Surgical Management—ten minutes

3. How can the Orthopedist help in the management of arthritis and other chronic diseases of the musculoskeletal system?—twenty minutes,

4. The management of menopausal syndrome and middle aged depression

Psychiatric-ten minutes

Gynecological—ten minutes

5. What can the State Rehabilitation Program provide in the management of chronic illness?—fifteen minutes.

Participants

Two internists

Two surgeons

One orthopedist

One psychiatrist

One gynecologist

One public health officer

A program of movies will run during addresses and unoccupied hours.

Making a Good Food Better"—twelve minutes, Dr. E. J. Lease, S. C. Experiment Station, Clemson.

The Roentgen Reckoner and Audio Probe"—ten minutes, Dr. Hillyer Rudisill, Charleston.

"Effect of Drugs on the Heart in situ"-twenty-five minutes, Department of Pharmacology, Medical College, Charleston.

"Experimental Aortic Valvulotomy"—ten minutes, Dr. H. G. Smithy, Medical College, Charleston, "Surgery of Bilateral Choanal Atresoa—Case Presentation"—twelve minutes, Dr. R. W. Hanckel,

Medical College, Charleston.
"Diseases of the Ear, Nose and Throat"—Organic Disorders of the Larynx"—forty minutes, Drs. Paul E. Holinger, A. H. Andrews, Jr., G. C. Anison and K. C. Johnson, University of Illinois College of Medicine, St. Łuke's Hospital and Children's Memorial Hospital, Chicago.

"Advent of Anesthetic Ether"—twelve minutes—Mallinckrodt Chemical Works, St. Louis, Mo.
"Signs and Stages of Anesthesia—Operative Shock"—thirty-nine minutes—Dr. I. W. Magill, West-

minster Hospital, London.
"Intravenous Anesthesia"—forty-two minutes, Drs. L. H. Mousel and E. B. Touhey, Medical Corps,

"Peptic Ulcer"-forty minutes, Dr. E. D. Kiefer, Boston University School of Medicine.

THE TEN POINT PROGRAM

M. L. MEADORS, EXECUTIVE DIRECTOR AND COUNSEL

HEALTH BOARD BILLS CONSIDERED

On Tuesday, February 17th, the Medical Affairs Committee of the Senate began consideration of the reorganization of the State Board of Health of South Carolina. Thus the Legislative body resumed the activity which was suspended near the close of the last session, following a public hearing at which officers of the South Carolina Medical Association and other interested parties expressed their views at length on the subject. In accord with the proposal made at that time, the Association, through a committee appointed for the purpose, had a careful study made, and at a special meeting of the House of Delegates in November adopted a Resolution embodying certain recommendations. These were incorporated in a proposed Bill which was submitted to the Chairman of the Medical Affairs Committee of the Senate in the early part of February.

In the meantime, several other proposals were made. At the meeting of the Committee on February 17th, there were before it at least three proposed Bills to reorganize the State Board of Health. The Bill recommended by the South Carolina Medical Association would provide for a nine-member Board consisting of five doctors, to be recommended by the Association, one dentist to be recommended by the State Dental Association, and three citizens outside these two professions, to be named by the Governor. The principal objection raised to this proposal has been that it did not include provision for a pharmacist on the Board. (A pharmacist has been a member of the Executive Committee of the present State Board of Health for a number of years.)

At the hearing before the Medical Affairs Committee on February 17th, there was a large delegation from the Pharmaceutical Association, present to urge that a pharmacist be included. There were also a considerable number of members of the State Nurses Association, who urgently proposed that a nurse too be added.

It was learned, in fact, a few days before the meeting, that a Bill had been prepared in the Engrossing Department, and which is understood to have the blessing of the Chairman of the Medical Affairs Committee, providing for an eleven-member Board of Health, consisting of the nine proposed in the Bill recommended by the Medical Association, plus a nurse and a pharmacist. This Bill included also another feature which was not in that recommended by the Medical Association. It would establish a State Department of Health to be under the direction of the State Health Officer and generally under the control of the proposed new State Board of Health. The structure thus outlined

would be very similar to that which now obtains with respect to education. The State Board of Education, consisting in part at least of ex-officio members, has general supervisory functions, but the actual executive and administrative work is performed by the State Department of Education, under the direction of the State Superintendent of Education, who is elected in the primary.

While under the proposed Bill, the executive head of the suggested Department of Health would be chosen by the new State Board of Health, it seems entirely possible that the plan might easily lend itself in the future to a suggestion for following further the pattern of the Department of Education, by providing for the election of the State Health Officer at the polls.

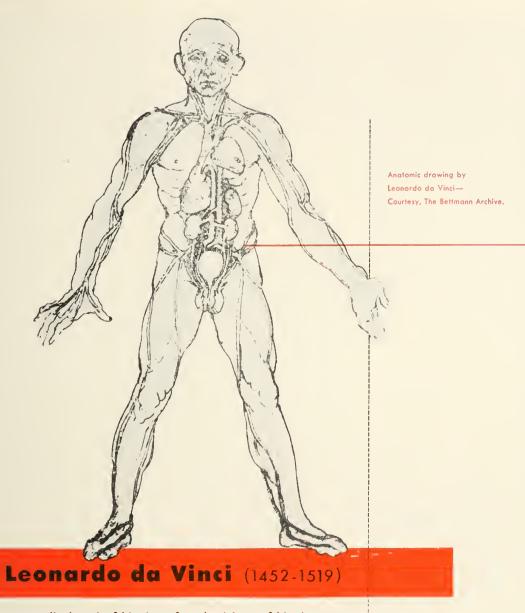
No final action was taken by the Committee on February 17th, and as this is written, no Bill has been introduced and nothing officially approved by the Medical Affairs Committee. Some definite action is expected however, in the immediate future (before this is read), and present indications are that the Bill to be introduced will provide for the eleven-member Board and the State Department of Health.

NATUROPATHIC CAMPAIGN WARMS UP

The News and Courier for February 17th carried a full story under the by-line of W. D. Workman, on the efforts of Representative Bob Ward of York County, and certain of his fellow members of the Medical Affairs Committee of the House of Representatives, to procure legislative action with regard to the practice of Naturopathy in South Carolina. It referred specifically to the Concurrent Resolution introduced and passed in the House last year, calling for a thorough investigation of the so-called profession and its Board of Examiners, which Resolution was likewise adopted by the Senate and returned to the House for appointment by the Speaker of the members of the investigating committee provided for. Shortly thereafter it was recalled to the Senate on the ground that it had been recorded as having passed, through error. Close examination of the daily journals of the upper legislative body for that period, however, gives no indication of such error and so far as the record is concerned, passage of the Resolution there appears to have been entirely regular. At that point, to quote Mr. Workman and the News and Courier, "on or about April 30th, the Resolution literally and completely disappeared, and to date no one has been able to determine what happened to the measure."

House Bill #779, introduced by the Medical Affairs Committee of the House last year, would prohibit

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was well ahead of his time, for physicians of his day knew little of the function of the heart or the treatment of its diseases, although da Vinci's knowledge of such anatomy was extensive. Physicians of today prescribe

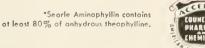
SEARLE AMINOPHYLLIN*

—a modern treatment for congestive heart failure, bronchial asthma, paroxysmal dyspnea and Cheyne-Stokes respiration.

Supplied for oral, parenteral and rectal use. G. D. Searle & Co., Chicago 80, Illinois.

SEARLE

RESEARCH
IN THE SERVICE
OF MEDICINE



Naturopaths from practicing obstetrics and gynecology and from the use of biologicals. This Bill has been on the calendar for second reading since April 24, 1947. and its progress since that time has been delayed by objection of Mr. Poliakoff, Representative from Spartanburg. Thus the measure was relegated to a place among the numerous contested matters there and has not been reached for further action. On Thursday. February 12th, an effort was made to refer the Bill back to Committee with the idea of its dying there, but the effort failed and at present the Bill remains on the calendar. According to the article in the News and Courier, Mr. Ward and his associates are determined, however, that it shall not remain in this status and further action is anticipated momentarily.

The disposition of the Resolution last year and the difficulties encountered by House Bill 779 appear to be entirely the result of the very active campaign being conducted by the Naturopaths and their representatives in opposition to any proposals to limit, refor, or even to inquire into the practices of the members of the Naturopathic persuasion.

MEMBERS ATTEND CHICAGO CONFERENCES

The medical profession of South Carolina was well represented at the February conference of the AMA in Chicago.

Dr. J. I. Waring and Dr. A. W. Browning attended the Conference on Rural Medical Service as representatives of the South Carolina Board of Health. Dr. Kenneth M. Lynch and Dr. John Boonc of the Medical College, attended the Conference on Medical Education, and Dr. Harold Gilmore and M. L. Meadors represented the South Carolina Medical Association at the National Rural Health Conference and the National Conference on Medical Service.

Dr. J. P. Cain, Jr. was also in Chicago at the time of the conferences, the period from February 6th to 9th. Prominent leaders interested in medical care in fields outside as well as within the profession contributed to the interest and success of the meetings.

NEW SURGEON GENERAL

Of interest to the profession generally, is the appointment of Dr. Leonard A. Scheele of Ft. Wayne, Indiana, to succeed Dr. Thomas Parran as Surgeon General of the United States Public Health Service. Apparently Dr. Scheele will take office on the expiration of the current term on April 6, 1948.

Dr. Scheele has been Assistant Surgeon General since July, 1947, and previous to that time was connected prominently with the National Cancer Control Program of the National Cancer Institute. He was commissioned in the United States Public Health Service in 1934, with which he was connected in varying

capacities until 1937. Dr. Scheele was born July 25, 1907, and educated at the University of Michigan and Wayne University in Detroit.

MEDICAL PUBLIC RELATIONS*

We repeatedly meet, as groups of doctors, to discuss our problems. Many of our ideas are good, but we tend to forget that the medical profession composes but a small proportion of the total population. It is true that our influence is disproportionate to our numbers, but our influence is not great enough to long allow us to run counter to public opinion, nor can we stem an overwhelming tide of adverse criticism.

We need to know what the public is thinking, not the professional agitators, but the common garden run who compose our practices. Perhaps the public is wrong. That makes no difference if they are not convinced. Unfavorable public opinion will engulf us unless we, first, put our house in order, and second, convince the public that their best interests lie in the continuation of the present system of the private practice of medicine.

In preparation for this talk I attempted to sample public opinion. I selected a group of people who had reason to know of medical problems in the community. To prevent personal bias, I largely avoided those who were patients of mine. Both men and women are represented. There are industrialists, employers of labor, personnel managers of large corporations, editors and publishers, judges of the courts, prosecuting attorneys, welfare workers, public health nurses, women on the boards of the Red Cross, Junior League clinics, child care centers, ministers who frequently serve as personal counselors, a radio station executive, a C. I. O. educational director, legislators, and others. To them I addressed a request for opinion as follows, "The medical profession realizes that its public relations are at fault. Some of the responsible factors are known to us as members of the profession, but the lay public, on and with whom we practice, has a different approach. I am to participate in a conference on Medical Public Relations, in Richmond, on December 20th. Would you list on the back of this sheet, the grievances of which you have knowledge, and points in which you feel the medical profession, both as individuals and as a group, fail in their efforts to maintain friendly public relations?

After all it makes little difference what the medical profession feels, if the lay public feels otherwise, By getting a cross section of local opinion, valuable ideas should be obtained."

The response was nearly 100%, and every reply showed thoughtful consideration of the subject. A few

Address of John T. T. Hundley, M.D., Lynchburg, Va., presented before Public Relations Conference, of the Medical Society of Virginia, Richmond, Virginia, December 20, 1947.



refused to commit themselves in writing but arranged conferences, where I let them do the talking, while I took notes.

The public is concerned with what they feel is the imminent approach to socialized medicine. They do not want the socialization of medicine, but they believe it is coming, and they will not fight the onset. Neither will they help the medical profession to fight, unless and until they see that the medical profession realizes and is making a sincere effort to correct its own faults and clean its own house.

The following are abstracts of the statements made to me. I have made no changes except a few minor ones in the interest of brevity.

There is LACK OF PERSONAL INTEREST in the patient. A scientific attitude, which treats the disease but forgets the individual. Patients feel they are run through the mill mechanically, and the old, friendly, personal attitude between doctor and patient is lacking. There is the feeling that the doctor thinks he is the important factor, 'when in reality I am'. Doctors do not take time enough to give individual attention, or make careful examinations.

The COSTS OF MEDICAL CARE have mounted to the point that only the rich, or the charity patient, can afford good medical attention. The average individual cannot stand the costs of an operation, or of a lingering illness. The poor man cannot afford to get sick. Surgical fees are exorbitant. Bankruptcies are due to three major factors as items of expense, doctor's bills, hospital bills, and borrowing from loan sharks, and 80% of the borrowing from the loan sharks is for the purpose of paying doctor and hospital bills.

There is OVERSPECIALIZATION which has unduly increased the costs, and at the same time rendered it more difficult for the average individual to get medical attention when needed. Excessive expense is involved in referring the patient from one specialist to another. More old-time general practitioners are needed. There is too much office work and not enough doctors are willing to make home calls. Overspecialization, and refusal to care for minor conditions in another specialist's field, increases cost by requiring more than one fee. The charge by the referring physician, merely for referring the patient to another specialist is unjustified. Overspecialization, carried to the foolish extremes, often encountered, is compared to the "feather bedding," a vicious, modern labor union practice.

The public is annoyed by the TECHNICAL JAR-GON used by the medical profession, instead of using simple understandable terms to patients and relatives. The average patient has not the knowledge the doctor assumes he has.

The public resents the EXCESSIVE INCOME of the medical profession. 'All the doctors are buying Cadillacs'. The public seems to feel that the profession's interest is in acquiring worldly goods, rather than the patient's salvation. Medical success is measured by the dollar mark.

There is LACK OF INTEREST in the insurance patient. The physician is working for the insurance company. There is refusal to refer the insurance patient to a better qualified specialist, for fear of losing the assured payment from the insurance company.

Doctors do not KEEP APPOINTMENTS. 'I wait for hours even though a definite stated appointment is made, and kept by me.' The doctor fails to realize that my time is as important to me, as his is to him. 'I am led to think that my doctor has made a special appointment to see me, but when I reach his office I find a dozen others have been told to come at the same time.'

PROFESSIONAL ETHICS are carried to a ridiculous extreme, and often handleap the patient in the free choice of physician.

Members of the medical profession fail to bear their proportionate part of the load of COMMUNITY ACTIVITIES. The private physician considers his obligation as satisfied by attention to the individual patient and acknowledges no obligation to the problems of community health.

Medical PUBLIC RELATIONS ACTIVITIES are poorly organized and inefficient. Professional men generally do a poor job in public relations, probably because of the prohibition against advertising. There arc grievous inaccuracies in the reports of medical meetings, and the profession should prepare and edit such reports. Newspaper columnists signing themselves as M.D. are unduly critical of the practicing physician. Science Service releases are premature and misleading. Physicians of reputation should write articles for newspapers and magazines to counteract the impressions conveyed by lay journalists writing pseudoscientific articles in the lay press. More publicity is needed to publicize the advances in medical knowledge and practice. Medical costs should be publicized in relation to (1) the costs of other public services, and (2) what the public is saved in suffering, invalidism, and life. Publicize hospital costs and faults by emphasizing that the public's failure to support them is responsible. Efforts should be made to create a more favorable understanding of the medical profession by 'replacing sentimentality with sense,' to assist the public to regard the doctor as a highly trained consultant rather than as a servant.

The medical profession lacks SOCIAL CON-SCIOUSNESS. There is an unjustified discrimination against the Negro both as patient and as physician. The medical profession refuses to support social legislation extending the coverage and benefits of medical care, implying by their attitude that "Nothing needs to be done; that the situation, as it exists today, is all right; and a large number of our people aren't receiving medical care—well that's just too bad."

There are severe INEQUALITIES IN THE DIS-

INSEPARABLY RELATED

"Now that we know the chemical nature of most of these compounds [internal secretions], and have learned much about their physiological activities, endocrinology has become an exact science, or branch of science, inseparably related to physiology, pharmacology and biochemistry."

Cameron, A. T.: Recent Advances in Endocrinology. ed. 5, Philadelphia, The Blakiston Company, 1945, p. 1.

The ever-widening scope of hormone therapy is the outcome of decades of progress in laboratory research, clinical investigation and pharmaceutical manufacture.

SCHERING

world's largest manufacturer of sex hormones has pioneered in noteworthy developments in this field.

Further advances in endocrine treatment foreshadowed by current scientific activity are inseparably related to the continuing initiation of effective, well-tolerated therapeutic agents.

CORPORATION • BLOOMFIELD, NEW JERSEY
IN CANADA, SCHERING CORPORATION LIMITED, MONTREAL

TRIBUTION OF MEDICAL CARE. "Though I resent socialized medicine I prefer it to the one doctor in 15,000 people now existing in some localities."

The public fears SOCIALIZED MEDICINE, and teels that unless the medical profession develops better public relations we will surely be forced into that state. "I wish to make myself plain that I am probably the last person in the world that would believe in the socialization of anything. I do, however, think that the sentiment in this direction is much stronger than most of you in the medical profession realize, and for your own salvation, and for the general philosophy of the American economic system, I hope you will make some real effort toward correcting this feeling."

Some of the suggestions above noted are of dubious value. Others can be explained by frank and free discussion. But, this is what the public is thinking, and it will take a real and effective public relations program to correct these sentiments, and change them into a favorable attitude toward the medical profession. One suggestion, only partially facetious, was that all doctors be required to take an intensive Dale Carnegie course on "How to make friends and influence people."

That is hardly the remedy. What then can we do? First we can analyze what the public is thinking.

What are the complaints that have been voiced?

A lack of personal interest in the patient. Excessive costs of medical care. Overspecialization often carried to ridiculous extremes. The use of technical jargon, rather than plain understandable terms. Excessive income of the medical profession, out of proportion to other professions and businesses. Abuse of insurance practice. Failure to make and keep appointments. Foolish and extreme application of the principles of medical ethics. Failure of doctors to carry their proportionate load in community activities. A poor, unintelligent public relations program. The lack of social consciousness on the part of the medical profession. Inequalities in the distribution of medical care. A definite fear that socialized medicine will result if the abuses are not corrected and corrected promptly.

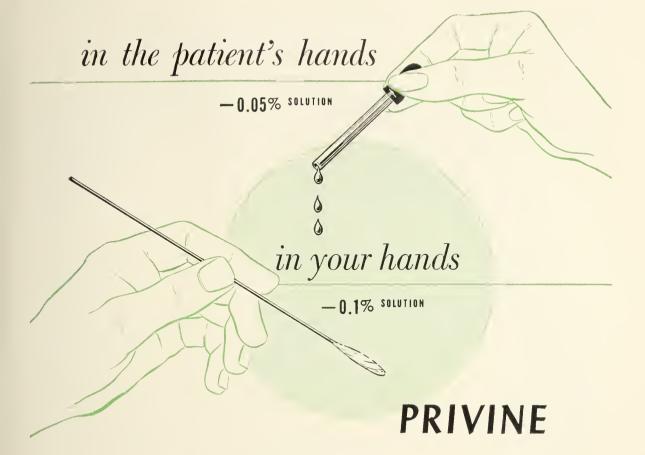
To many of these complaints we can plead gnilty, and it is only when we acknowledge our faults that we reach the mood where we are ready to take effective action. There is great merit in the old evangelical principle that salvation only follows repentance.

Some of these things can be corrected only by planning, and execution of the higher organizational levels, but many of them are matters which must be brought to the attention, and corrected by the local society, and the individual physician. The most important and the most convincing Public Relations activity is that which takes place at the local level. There are two approaches at that level. One and probably the most important, is the contact of the individual doctor with his patient.

THE INDIVIDUAL APPROACH-The patient's problems are personal. Whether it is too or head ache. whether the cause is infectious, circulatory, or emotional, the patient complains of symptoms which are of extreme importance to him. He will generally cooperate and be appreciative if he is treated as an intelligent human being. If appointments are promptly kept, or if that is impossible, reasonable explanation and apology is made; if careful study and examination is given; if reasonable explanations are offered to the patient; he will in most instances have confidence and give cooperation. But if he finds himself in a crowded office, is forced to wait long periods although he had a definite appointment, if he is rushed in and out of the office with little opportunity to explain his symptoms and no more for examination and study. given a prescription, without explanation of the condition, the treatment or the prognosis; he will consider the charges for such services to be excessive, and feel that perhaps state medicine can offer as much. If he leaves that doctor's office and becomes an advocate for state medicine I would not blame him, After all private medical practice has one big assurance to offer, and that is personalized service. If the patient is treated as just another in a production line in the private physician's office, he might as well go the whole way and have the relatively painless deduction from his pay envelope to pay for production line state medicine.

PARTICIPATION IN COMMUNITY ENTER-PRISES OF MEDICAL INTEREST AND IMPORT should be both the duty and the privilege of the private physician. Too frequently do doctors fail to take an active interest in the operation of local organizations which are concerned with medical care, or which have medical interest and contacts. Later, after failing to participate in the organization and operation of such agencies, they are very free in their criticism of features of the operation of which they do not approve. Of course participation takes time, but it is worth it. In the past members of the medical profession demonstrated a totally unjustified aloofness from mundane affairs. Such an attitude was not justified then, and certainly cannot be justified now.

MEDICAL FEES are the concern of every member of the profession. Nothing receives wider comment than a report of an excessive charge which has worked hardship. It is unquestionably true that many fees are too high. No fair minded physician will deny that. It is not only the big fee which may be excessive. But, to leave out the matter of the excessive fee which is disproportionate to the service rendered, there remains the incontrovertable fact that good medicine is expensive, and is becoming more so. Hospital beds, nursing care, laboratory and x-ray services, and expensive therapeutic procedures, are more and more essential as medical knowledge grows. It cannot be denied that the costs of illness constantly mount to levels above the ability of very large groups of the population to meet without assistance. Governmental





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assistance is suggested, on the basis of compulsory taxation. Few of us believe that to be the acceptable remedy, and we can suggest another, and one better.

The individual physician should, even must, help his patients to secure voluntary insurance to meet the catastrophies of serious illness. Only by such means can the wage earner, or average white collar worker, meet the heavy costs of illness. We, as private physicians, have a vital role in spreading the number of those covered by the Blue Cross and Blue Shield plans of prepaid hospital and medical care.

Other means of influencing public opinion to a more favorable attitude toward the medical profession can best be utilized through the activities of the LOCAL SOCIETIES. The number and variety of those efforts will depend upon the initiative and energy of the membership.

GROUP MEETINGS should be arranged. Local organizations patterned on the Virginia Health Council should be organized in each community. In meetings of such groups can be discussed medical needs and problems, facilities and services, tuberculosis control, Red Cross cooperation, mental hygiene programs, rural medical needs, crippled children's activities, dental services, cancer control, prenatal and maternal health problems, nursing care, and all the various activities which center on or closely affect the medical profession and its activities.

LOCAL ORGANIZATIONS AND CLUBS should be encouraged to have programs of medical interest and speakers should be provided. Woman's clubs, and civic luncheon clubs, parent-teacher organizations, labor unions, veterans organizations, colleges and schools, home demonstration groups, all the numerous organizations which are so characteristic of American life, are constantly in search of programs and speakers. The local medical society, and its members, are missing a great opportunity, and failing in their duties, if they do not encourage and participate in the presentation of medical topics of such representative groups.

The medical profession has nothing to sell but service. And, as a corollary, the medical profession can speak with authority only on the subject of medical services. The public is interested in our problems only as they relate to their own personal lives and situations. We have no vested interest that anyone is bound to respect.

Our needs are basically two. First, to provide good medical services, and, second, to demonstrate conclusively to the public that the services we provide are the best, and will continue to be the best, under the present system of free and untrammeled private practice of medicine.

That can only be done if the profession is fully alerted to the actual emergency which exists. It can only be done if we see the dirt in our own house, and institute prompt cleaning. The very best in public relations efforts are required, and the most effective are those which take place at the level of the individual with his patient, and the local medical society in the community.

DEATHS

Dr. Irving S. Barksdale, 49, of Greenville, died February 10, following a sudden illness.

For seventeen years Dr. Barksdale screed the city of Greenville as city health commissioner. For the last three years he had engaged in private practice there.

A native of Richmond, Va., Dr. Barksdale received his degree in medicine at Yale. He served with the AEF in France during the first World War, and prior to going to Greenville had taught physiology at the Medical College of South Carolina. After leaving the health commissionership, Dr. Barksdale engaged in private practice in Greenville and was one of the leading members of the medical profession there.

Dr. William Sydney Burgess died at Tuomey Hospital in Sumter on January 31 after an illness of several weeks.

Dr. Burgess was born February 28, 1890, at Stateburg. He received his medical training at the Medical College of South Carolina and did post graduate work at Johns Hopkins, the New York City Lying-in Hospital, the University of Leeds, England, and at the University of Mt. Pelier in France. For the past 36 years Dr. Burgess was a practicing physician and surgeon of Sumter. For a number of years he was head

of obstetrics at Tuomey Hospital.

Dr. Burgess is survived by his widow, the former Miss Sallie Wright, two daughters, one son, two sisters and a brother, and two grandchildren.

Dr. Furman T. Simpson, 65, of Westminster, died at his home from a heart attack on January 29th.

Dr. Simpson was a graduate of Johns Hopkins Medical School and had been practicing medicine in Westminster for the past 40 years. A veteran of World War I, he served as chairman of the Westminster board of health and as health officer for Oconee County during World War II.

Dr. Simpson is survived by his wife, one son, two daughters, one brother and four sisters.

Dr. William E. Hicks of Sardis, died in a Florence Hospital on February 8th, after an illness of several months.

For 38 years Dr. Hicks served Florence County as a general practitioner. He was one of the most beloved citizens of his community.

Dr. Hicks is survived by his widow, the former Miss Lille Truluck, two daughters, one son, three brothers and six sisters.



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NEWS ITEMS

Dr. Charles N. Wyatt of Greenville is President of the Tri-State Medical Association for this year. Installation of officers was held at the recent meeting in Charleston. Other officers from South Carolina are Dr. W. Steele Dendy of Pelzer as vice president, and Dr. W. R. Wallace of Chester, Dr. R. L. Crawford of Lancaster and Dr. F. E. Kredel of Charleston as Councilors.

Dr. L. C. Floyd, son of Dr. and Mrs. L. C. Floyd of Olanta, has opened offices in Florence for the general practice of medicine.

Dr. George T. Noel, who has been engaged in the general practice of medicine in Lancaster, is now at Barnes Hospital in St. Louis where he has a residency in ophthalmology. Dr. Noel expects to be away from South Carolina approximately a year and a half.

Dr. W. C. Cook of Columbia is in Baltimore attending a three months course in cerebral palsy with Dr. Winthrop Phelps of John Hopkins.

Dr. Kathleen A. Riley has announced the opening of offices in Charleston for the practice of dermatology and syphilology.

Dr. William Wilson, formerly of Abbeville, has completed his medical course at John Hopkins. He plans to practice orthopedic surgery in Charleston.

Dr. Caroline H. Callison has transferred from the Greenwood County Medical Society to the Medical Society of South Carolina in Charleston.

Dr. William C. Cantey of Columbía was certified by the American Board of Surgery at a session held in Baltimore in December.

Dr. J. D. MeNair is in Latta again practicing with Dr. W. S. Bethea. Since 1946, when he first practiced in Latta, Dr. McNair has been at the Graduate School of the Medical School of the University of Pennsylvania and has served a Residency in Medicine at St. Joseph's Infirmary, Atlanta, Ga.

Dr. Harold S. Gilmore of Nichols is President of the Pee Dee Medical Association for this year, Dr. Gilmore is also Chairman of the Committee on Rural Health of the South Carolina Medical Association. He attended the annual Conference on Rural Health in Chicago in February.

The members of the Chester County Medical Society were guests of Dr. and Mrs. W. R. Wallace on January 12, at the regular monthly meeting of the Society. Dr. Furman Wallace and Dr. E. M. Colvin of Spartanburg were the guest speakers. Other guests present were Drs. Roderick MacDonald and A. Hinson of Rock Hill, and Drs. C. S. McCants and Douglas of Winnsboro. Officers of the Society for 1948 are: President, Dr. W. J. Henry; Vice President, Dr. G. A. Hennies; Secretary-Treasurer, Dr. Conrad Smith.

Josiah Kirby Lilly, chairman of the board of directors of Eli Lilly and Company, dicd on February 8, 1948. He was 86 years old.

Mr. Lilly was born in Greeneastle, Indiana. His father, Colonel Eli Lilly, founded the company on May 10, 1876. Josiah Kirby, as "a boy with a wicker basket," delivered the first pound of a Lilly product to a near-by wholesale druggist. He was then 14 years old.

In 1880, he entered the Philadelphia College of Pharmacy and Science, from which he graduated in 1882. Upon returning to Indianapolis he became superintendent of the plant, in which capacity he continued for about sixteen years. When Colonel Lilly died in June, 1898, his son was elected president of the company. After thirty-four years as president, Mr. Lilly became chairman of the board of directors in 1932. He retired from active service with the company on January 1, 1945.

Under his management Eli Lilly and Company became one of the outstanding organizations in the pharmaceutical field, with international distribution.

The Areal Meeting of the American Academy of Pediatrics will be held at the Statler Hotel, Buffalo, New York, April 29th to May 2nd, 1948.

Members of the State Medical Societies are welcome to attend. The registration fee will be \$5.00 for such non-members together with a \$5.00 registration for which each registrant receives a ticket to the banquet, making a total registration fee of \$10.00.

Registration may be made ahead of time by writing to Dr. C. G. Grulee, Secretary-Treasurer, American Academy of Pediatrics, 636 Church Street, Evanston, Illinois, enclosing a check for \$10.00 or registration may be at the time of the meeting.

Emory University School of Medicine announces a Postgraduate Course in Electrocardiography, May 17 to 21, 1948.

Emphasis will be placed on the elinical interpretation of the electrocardiogram in the light of modern excitation theories and the newer techniques in electrocardiography. The uses and interpretation of multiple chest leads, unipolar leads, the ventricular gradient and variation in normal patterns will be stressed.

In addition to the Emory University Faculty, guest speakers who will participate in the program are:—

Dr. George Burch, Tulane University Captain Ashton N. Graybiel, Medical Corps, U. S. N.

Registration Fee—\$40.00.
Make application to:—
Director, Postgraduate Education
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The Carolina Chapter of the American Physical Therapy Association offers Advisory Service for the placement of physical therapists in North and South Carolina.

Frequently qualified physical therapists request information on physical therapy vacancies in this area. If any organization, hospital or physician wishes assistance in securing this personnel, please contact Mary C. Singleton, Relations Chairman, Carolina Chapter, Duke Hospital, Durham, North Carolina. Kindly describe the position and state the necessary qualifications.

The second annual meeting of the South Carolina Obstetrical and Gynecological Society will be held on Saturday, April 3rd, at 2:00 P. M. at the Court Inn

in Camden.
Dr. "Nick" Carter, professor of obstetrics and gynecology, Duke University Medical School, will deliver the address on gynecology. Dr. Frank Lock, deliver the address on gynecology. Dr. Frank Lock, professor of obstetrics and gynecology, Bowman Gray School of Medicine, Wake Forest College, will deliver the address on obstetrics. Dr. Rowland F. Zeigler, Jr., F.A.C.S., Florence, will read a paper on "Saddle Block Anesthesia in Obstetrics." The president's address by Dr. L. A. Wilson, Charleston, will be on "The Management of Breech Deliveries.

All members of the South Carolina Medical Association are most cordially invited to attend this interesting

meeting.

The Sixteenth Annual Assembly of The Southeastern Surgical Congress will be held in Hollywood, Florida, Hollywood Beach Hotel, April 5, 6, 7, 8, 1948.

The following surgeons will appear on the program.

Dr. Herbert Acuff, Knoxville, Tenn.

Title to be announced.

Dr. Harry Bacon, Philadelphia, Pa.
"Surgical Management of Cancer of the Lower Bowel Without Colostomy."

Dr. Frederick Boyce, New Orleans, La.

"Human Bites.

Dr. Lester A. Brown, Atlanta, Ga.

Title to be announced.

Dr. A. F. Burnside, Columbia, S. C.

Title to be announced.

Dr. George Curtis, Cleveland, Ohio "The Surgery of the Spleen."

Dr. M. Y. Dabney, Birmingham, Ala.

Title to be announced. Dr. J. W. Devinc, Jr., Lynchburg, Va.

Title to be announced.

Dr. L. W. Dowlen, Miami, Fla.

Title to be announced.

Dr. Gilbert Fisher, Birmingham, Ala.

"The Conservative and Surgical Management of Esophageal Obstruction.'

Dr. L. J. Gariepy, Detroit, Mich. "Carcinoma of the Gallbladder." Dr. Arnold Griswold, Louisville, Ky.

'The Treatment of Peptic Ulcer by Resection of the Vagus Nerves.

Dr. William G. Hamm, Atlanta, Ga.
"Plastic Repair of Injuries of the Male Genitalia."

Dr. Claude J. Hunt, Kansas City, Mo. "Surgical Treatment of Malignant Lesions of the Colon Complicated by Inflammatory Reaction, Fixation or Obstruction.

Dr. Rudolph Jaeger, Philadelphia, Pa. "Intracranial Aneurysms; Surgical Treatment."

Dr. Frank A. Johns, Richmond, Va.

'Cancer of the Colon."

Dr. J. Harvey Johnston, Jr., Jackson, Miss.

'Acute Cholecystitis.

Dr. Willoughby Kittredge, New Orleans, La.

"Subcapsular Nephrectomy: Its Indications and Advantages

Dr. Herman Kretschmer, Chicago, Ill.

"Some Problems Associated with Surgery of Kidney Stones.

Dr. Ira Lockwood, Kansas City, Mo. "Non Obstructive Lesions of the Colon."

Dr. J. G. Lyerly, Jacksonville, Fla.

Title to be announced.

Dr. Robert Major, Augusta, Ga. "Transthoracic Approach to Lesions of the Eso-

phagus and Upper Abdomen."
Dr. Samuel F. Marshall, Boston, Mass.

"Tumors of the Neck."

Dr. George H. Martin, Vicksburg, Miss.

"Congenital Anomalies of the Gastro-Intestinal Tract in Infants and Children.

Dr. Charles Mayo, Rochester, Minn.

"Surgical Procedures for Carcinoma of the Lower Colon and Rectum.

Dr. Julian M. Moore, Asheville, N. C. "The Management of Homothorax,"

Dr. Carl Moyer, Dallas, Texas
"Alterations in Renal Function of Man Incident to Operative Trauma and Anesthesia.

Dr. Martin Nordland, Minneapolis, Minn.
"Fundamental Principles in Throidectomy."
Dr. L. M. Orr, Orlando, Fla.

Title to be announced.

Dr. E. G. Ramsdell, White Plains, N. Y.

"Carcinoma of the Breast, A Comparative Statistical Study.

Dr. Fred Rankin, Lexington, Ky. "The Surgical Treatment of Polyposis." Dr. Henry K. Ransom, Ann Arbor, Mich. Experiences with Total Gastrectomy. Dr. James F. Robertson, Wilmington, N. C.

Title to be announced.

Dr. R. L. Sanders, Memphis, Tenn.

Title to be announced.

Dr. William L. Sibley, Roanoke, Va.
"Lead Poisoning in Infancy, a Case Upon Whom
Two Unnecessary Operations Were Performed."

Dr. Dargan Smith, Owensboro, Ky. "Glycerin Osmotic Drainage in Peritonitis."

Dr. Ambrose Storck, New Orleans, La.

Title to be announced.

Dr. Walter Stuck, San Antonio, Texas "Complications of Fractures of the Shaft of the

Dr. H. G. Smithy, Charleston, S. C.

"An Approach to the Surgical Treatment of Chronic

Valvular Disease of the Heart."

Dr. Charles C. Trabue, Nashville, Tenn.
"Plastic Procedures for the General Surgeon."

Dr. Joseph Webb, Huntington, W. Va. 'Needle Biopsy of the Liver in Diagnosis of 'Surgi-

cal' Jaundice

Dr. R. S. Widmeyer, Parkersburg, W. Va. "Child and Infant Surgery.

Dr. David A. Wilson, Greenville, S. C. "The Treatment of Bilateral Apical Pulmonary Tuberculosis.

Dr. John M. Wilson, Mobile, Ala.

"Management of Intestinal Obstruction."

BIRTH ANNOUNCEMENTS

Dr. and Mrs. L. H. Taylor of Greenville announce the birth of a daughter on January 14, in Greenville.

Dr. and Mrs. C. K. Lindler of Columbia have announced the arrival of a son on December 31, in Columbia.

Dr. and Mrs. R. L. Cashwell of Greenville are being congratulated upon the birth of a daughter on January

Pathological Conference, Medical College of the State of South Carolina

KENNETH M. LYNCH, M.D., PROFESSOR OF PATHOLOGY

ABSTRACT #602

Student I. H. Arnold (presenting):

HISTORY: A 55 year old white man admitted to a local hospital on May 16 with history of pain between shoulders radiating around waist and along costal margins since March. Pain constant and occasionally sharp, but without relation to meals or activity. Two weeks before admission noticed increasing weakness of legs, which was most marked in right and necessitated the use of crutches. Right leg apparently paralyzed on admission and left leg paralyzed 2 days later. Family physician dated paralysis to the extraction of teeth. At time of admission no bowel movement for 4 days, but patient had "chronic constipation." He mentioned "seeing double" and 3 days later he was unable to open right eyelid. He complamed of headache and backache. Examination revealed: Rt. pupil dilated and fixed with ptosis of lid; right eye did not move with field of vision, left eye and fundi normal. Pain over lower ribs (below 7) but no discomfort on heavy palpation over spine; no heat, pain or touch below 8th rib anteriorly and laterally. Position sense in legs retained; rectus abdominis and leg muscles flaccid; no abdominal, cremasteric, patella, ankle or plantas reflexes, no clonus. Arm reflexes normal. All these findings were not recorded on admission, but have been pieced together in sequence from subsequent histories and examinations. After 2 days in hospital he was unable to void and an indwelling catheter had to be placed. At time of discharge he was unable to pass urine or flatus voluntarily.

Discharged in 10 days for admission to Roper. (One history taken recorded that the weakness had been progressive over a period of 2 years; no one else recorded this, however).

PAST HISTORY: Hospital admission for rheumatism 28 to 30 years before. Admitted to Roper in 1928 for liver trouble. Recently told after X-ray that "valves of his liver were stuck." History of gonorrhea, but year not stated. "Mole" removed from back 2 years before said to "have the makings of a cancer" and was followed by 20-X-ray treatments. History of frequency for 2 to 3 years and constipation for 4 to 5 years.

PHYSICAL EXAMINATION: (At Roper) chronically ill white male with T 98.6, P 86, R 22, B/P 124/70. Total opthalmoplegia of right eye with ptosis of lid and dilated fixed pupil which did not react. Left eye showed weakness and external rectus and pupil reacted to L & A. Visual acuity fair in both eyes. No papilledema. There were coarse rales in both lungs and thoracic movements were decreased in amplitude. Apical systolic murmur. Abdomen moderately distended and tympanitic with tenderness in upper

abdomen and palpably enlarged bladder. Bilateral costo-vertebral angle tenderness. Prostate firm and not enlarged. Anal sphincter atonic. No muscular atrophy. Knee and ankle jerks absent. Plantar reflexes absent. Biceps and triceps hypoactive. Loss of pain sensation below T 10. Sensation to deep touch and position sense impaired, more so on right side. Flaccid paralysis of legs. (There is some disparity in the history and physical findings by different examiners—the concensus of opinion has been used).

ACCESSORY DATA:

RBC 4.14 million, WBC 19,000 Hgb 11.5 cms, Pmm 91 %

Urinalysis, Sp. Gr. 1.016 Alb. ++ Pus 100 HPF.

B.U.N. 17 mgm. Wassermann neg.

Spinal fluid (reported as clear by laboratory, slightly xantho chromic by intern). 2 lymphocytes Proteins—278 mgms. Wass. neg.

COURSE IN HOSPITAL: Increasing restlessness, irrationality cyanosis, and eventual stupor and coma. Lumbar puncture—1st puncture bloody. 2nd at a different level with pressure of 20 mm., neg. Queckenstedt, closing pressure of 0. Gradually increasing temperature, pulse and respirations. Death 3 days after admission.

Dr. D. B. Remsen: (conducting) Mr. Smith, will you discuss this case?

Student E. Y. Smith: It is difficult to imagine one disease process accounting for this entire picture unless metastatic malignancy is considered. The central nervous system lesions are located in the thoracic portion of the spinal cord and in the mid brain area making it impossible for a single lesion to account for all the symptamtology. Was there a blood phosphatate determination?

Student Arnold: No.

Student Smith: One possibility, of course, is carcinoma of the prostate. This could account for the urinary and bladder findings of cystitis and probably pyelonephritis. The central nervous system lesions could be due to vertebral metastases with destruction of bone and compression of the spinal cord. Such symptoms of pressure are usually unilateral at the beginning or at least not equal bilaterally. Superficial sensations such as pain and touch would disappear early and later deeper sensations such as position sense would be involved with eventual paralysis. This paralysis would be of paraplegic type with atonia of the bladder and the colon. Pressure producing such a lesion can result from a process within the spinal cord itself or from without. Intramedullary lesions to be considered would be primarily neoplastic, such as ependymoma or glioma. Both of these are usually more segmental in their effects and do not ordinarily produce complete cord transection. Another possibility is 23

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*Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60; Proc. Soc. Exp. Biol. and Med., 1934, 32, 241; N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592.



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the rare multiple telangiectasia of the central nervous system which could be related to the history of a mole. There would be loss of pain and temperature with a radiculitis and block of the spinal canal with a Froin syndrone in which the spinal fluid is xanthrochromic and shows an increased protein content. With such multiple telangiectasias, a process in the region of the cavernous sinus could cause pressure on the 3, 4 and 6th nerves with involvement of the corresponding extraocular muscles. However, in such a process visual impairment would ordinarily be expected as well.

Dr. Remsen: Please discuss lower motor neuron lesions.

Student Smith: The lower motor neuron lesion is frequently segmental in distribution and results in flaccid paralysis, absence of reflexes, and eventual muscular atrophy and atrophic changes such as ulceration or possible Charcot joints.

Dr. Remsen: What about some vertebral process such as Pott's disease?

Student Smith: There is no spinal deformity nor is there any discomfort on heavy percussion in the spinal region. I rule out tuberculosis on the absence of spinal deformity, the multiplicity of sites involved with the absence of definite spinal fluid changes. Hypertrophic arthritis is a possibility which could result in osseous spur formation with impingment on the nerve roots, but this is a slow process. The history of two years duration might fit such a picture, but certainly two months is much too short a time for such a process. My first consideration would be a metastatic malignancy involving the central nervous system, Carcinoma of the prostate could produce this picture but physical examination reveals no enlargement, nodularity, or undue induration of the prostate. Carcinoma of the lung could also produce this picture but there is no evidence pointing to the pulmonary system. A mole, referred to in the history, which was removed and had 20 post operative X-ray treatments indicates that this process was considered dangerous.

Dr. Remsen: The family physician dates the onset of the symptomatology to the extraction of the teeth. Would you comment on this.

Student Smith: Such a process would almost inevitably be septicemia which would run a much more rapid course and the patient should be much more septic. Multiple abscesses of the central nervous system would probably result in more definite changes of the spinal fluid and there should be pyemic abscesses elsewhere

Dr. Remsen: Mr. Hand, would you comment on the possibility of multiple sclerosis.

Student R. H. Hand: The age of onset of symptoms of multiple sclerosis is usually the young adult group into which this patient does not fit. Lesions occurring in the thoracic and the upper thoracic segment results in flaccid paralysis of that particular region and spastic

paralysis of the lower limbs. This case shows no involvement of the upper extremities and the paralysis of the lower extremities is of flaccid type. The hyperasthesias and anethesias in this case might be compatible with multiple sclerosis, but the lack of history of remissions and exacerbations as well as the reflexes indicated on physical examination are definitely against such a process.

Dr. Remsen: One of the frequent features of multiple sclerosis is the occurrence, at least transiently, of double vision. This patient referred to double vision. Would you comment on that.

Student Hand: Double vision in this case probably was the result of extraocular paralysis. For this to occur in multiple sclerosis would be unusual, for that disease usually involves the 5, the 7 and 9th cranial nerves whereas this ease showed involvement of the 3, 4 and 6th. Since this case developed as a reticulitis, followed by subarachnoid block and Froin syndrome, loss of pain and temperature sensations and subsequent development of flaccid paralysis, I think the best bet is an extramedullary intradural mass. A similar mass would explain the involvement of the cranial nerves. Certainly a malignant melanoma could produce such metastases and my inclination is to incriminate the mole treated two years ago. Metastatic carcinoma from prostate or lung could produce such pictures. Masses produced by multiple neurofibromatosis or von Recklinghausen's disease could also produce such symptoms, but the course of the disease and lack of cutaneous nodules do not fit. Myelitis is a possibility and could account for the root pain. The onset of this disease is usually abrupt and there are ordinarily other evidences of inflammation or infection such as an elevated temperature. However, it could be of virus type or possibly toxic, such as due to heavy metal poisoning. The toxic type, particularly those due to heavy metals, do not ordinarily run such an acute course or result in death. The virus type, or so called Landry's paralysis, is of ascending type and the progress of the disease usually rapid, with death resulting from medullary involvement. My final diagnosis would be more or less divided between spinal cord neoplasm, probably metastatic, and multiple neuritis of the Guillain-Barre' type.

Dr. Remsen: Mr. Ferrera, what do you thing of syringomyelia?

Student B. Ferrara: Syringomyelia usually has onset with loss of pain and trophic disturbances. The paralysis is more apt to be spastic than flaccid which would result in hyperactive reflexes. I agree with Mr. Hand regarding multiple sclerosis. Multiple neuritis of the Guillain-Barre' type is a possibility to be questioned. The onset with rise in temperature could be related to an upper respiratory infection or other infectious process. The paraplegia, loss of deep reflexes and cranial nerve involvement can all occur in this process.

Dr. Remsen: Mr. Bolin, what is your impression?

Student G. C. Bolin: Frankly, I had not considered multiple neuritis of the Guillain-Barre' type. The involvement of the cerebral nerves could be accounted for on the basis of disease of the cranial bones such as Padgett's disease, but such a process would usually involve the optic nerve with visual symptoms as well. Certainly metastatic malignancy would be extremely difficult to rule out and is my first choice.

Dr. Remsen: In concluding I too feel that history of removal of the mole followed by 20 X-ray treatments is of considerable significance. The absence of any report of biopsy or pathological examination certainly confuses the issuc.

Dr. Olin B. Chamberlain: The point that I would like to make is that the issue is also extremely confused by the disparity in the recorded examinations by various people in this case. None of the three or four examinations agrees completely with the other and in the final analysis we cannot even say whether the process was acute or chronic, for the history varies from two months to two years. Certainly I am tempted to accept the history of two months duration for this would fit a metastatic malignancy involving the cord at the level of T8 and with cranial involvement resulting in ophthalmoplegia. The term mole usually covers a multitude of lesions and without further knowledge as to the type I would not hazard any final statement. Certainly I do feel that it is the key to the situation. Another point is that if the 3rd nerve is seriously involved it takes a very cautious and meticulous examination to find function in the 4th and 6th nerves.

Dr. F. E. Kredel: Certainly we cannot ignore the history of a mole with its subsequent irradiation. I feel that this must be a metastatic malignancy, but one must also keep in mind such bone lesions as multiple myeloma which is a distinct possibility.

Dr. H. R. Pratt-Thomas: Final Pathological Diagnosis: Malignant Melanoma, Metastatic to Sphenoid Bone, Heart, Liver, Lung, Intestine, Ribs and Vertebrae with Compression Muelitis.

It is reassuring that nearly everyone was suspicious that the ubiquitous melanoma was lurking in this case. A pitted scar 1.5 cm. in diameter was present over the middorsal spine, but there were no cutaneous manifestations of the disease. We do not have the mole that was removed in our files and have been unable to find out if it was ever examined by a



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pathologist or in what manner it was originally removed.

There were pathologic fractures of the second and fourth ribs in the posterior axillary line on the right and were related to masses of grayish neoplastic tissue. To the right of the seventh and eighth vertebra was an extra-pleural neoplastic mass and these vertebral bodics were eroded and partially collapsed. The tumor extended into the spinal canal extradurally and compressed the spinal cord posteriorly for a distance equivalent to the two vertebrae.

A tumor mass had destroyed a portion of the sella floor, the posterior clinoid processes, elevated the dura and compressed the pituitary posteriorly.

Histologically the tumor consisted of alveolated clumps of round and polyhedral cells, but in some of the metastatic foci, notably the heart, they assumed a spindle form. Extracellular brown pigment was found within some of the tumor cells in the lung but the remainder of the tumor was amelanotic.

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BLUE SHIELD ADOPTED NATIONALLY

BLUE SHIELD has been adopted as the official name and insignia for the non-profit, prepayment medical care plans in the United States, as the result of action taken recently by the Commission of Associated Medical Care Plans.

Prior to the establishment of AMCP in 1946, several medically sponsored prepayment plans had begun to use a BLUE SHIELD symbol on their literature, the practice having originated in 1939 with Western New York Medical Plan in Buffalo, New York.

Having secured permission from eighteen plans already utilizing the insignia, the AMCP Commission adopted BLUE SIHELD as the official service mark for its forty-eight member plans.°

BLUE SHIELD, in name and symbol design, has been filed for registration with the U. S. Patent Office under the revised federal statutes, permitting a service mark for intangible services to be protected.

mark for intangible services to be protected.

"We hope that BLUE SHIELD will gain the same widespread public acceptance, identifying the prepayment programs sponsored by the medical profession, as Blue Cross has achieved in the hospital field," stated Frank E. Smith, Director of AMCP,

The adoption of BLUE SHIELD will not replace the Seal of Acceptance of the AMA, awarded by the Council on Medical Service to prepayment plans which have complied with established minimum standards. The AMA approval program will continue, without reference to the fact that a prepayment plan under consideration for approval may be known as a BLUE SHIELD plan.

Before AMCP accepts a prepayment plan as a full member, entitling that plan to use the BLUE SHIELD insignia, the AMA minimum standards must be fulfilled, the AMCP Commission reserving the right to pass judgment on such fulfillment in the absence of a previous decision by the AMA Council on Medical Service.

In effect, all BLUE SHIELD plans comply with the AMA standards of approval. If the Seal of Acceptance has not been granted to a BLUE SHIELD plan, explanation lies in the fact that application for such approval has not been submitted. Several BLUE SHIELD plans fall within this category.

On the other hand, a few prepayment plans, having been awarded the Seal of Acceptance, have not made application for AMCP membership.

The situation might appear confusing to those who are not intimately familiar with the prepayment plan movement.

The easiest way to distinguish the two symbolisms is to remember that the Seal of Acceptance, granted by the AMA Council on Medical Service, indicates AMA approval. BLUE SHIELD is a promotional device, adopted by AMCP and its member plans, all of whom follow the non-profit principle of operation.

Whether referred to over the radio, in advertising copy, or news releases, BLUE SHIELD provides an easily recognizable verbal and visual means of identifying the nation's non-profit plans for prepaying the costs of medical care.

On January 1, 1948 the non-profit plans recorded a total enrollment in excess of 7,000,000 persons.

The AMCP Commission expects to act on six additional applications for membership at its meeting on March 26-27,



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*Barr, Joseph S., Ruptured Intervertebral Disc and Sciatic Pain, Jr. Bone and Joint Surg., 29: 429-437 (April) 1947.

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WOMAN'S AUXILIARY SOUTH CAROLINA MEDICAL ASSOCIATION

President: Mrs. D. F. Adcock, Columbia, S. C.

Publicity Secretary: Mrs. Kirby D. Shealy, Columbia, S. C.

AUXILIARY MEETS AT ORANGEBURG

The Medical Auxiliary of Orangeburg had its most outstanding meeting of the year January 27th at the home of Mrs. Vance W. Brabham in Orangeburg, Mrs. G. P. Cone and Mrs. Wells Brabham were assistant hostesses. The meeting was called to order by the president, Mrs. L. P. Thackston, and a brief business session followed. At the end of the business the group session followed. At the end of the business the group was invited to the dining room for a lovely buffet luncheon. After the luncheon Mrs. Thackston introduced Mrs. David F. Adcock, president of the state Auxiliary, who was guest speaker. She gave a most interesting and inspiring talk in which she stressed the two state-wide goals, the enlistment of members and nurse recruitment. Her ideas and suggestions were a challenge to the group to attempt bigger things in the months to come. It was indeed a pleasure and inspiration to have her meet with us.

Mr. Rustin, city school superintendent, presented some ways we might help in the school health program. The Auxiliary decided to work toward getting a physical examination for each girl and boy during the school year.

After this the meeting was adjourned.

REMINDER

We would like to remind you of two things: first, that county historians should be sending pictures and sketches of past presidents to the Centennial Committee in Charleston; and second, that March 30, the day on which ether anaesthesia was discovered by Dr. Crawford W. Long of Georgia, is Doctors' Day and some appropriate observance should be made by all Auxiliaries.

THIRD DISTRICT AUXILIARY MEETS

The Woman's Auxiliary to the Third District of the South Carolina Medical Association held its second meeting since organizing Tuesday evening, January 16, at the Oregon Hotel at Greenwood. A Dutch supper was enjoyed. After the supper the meeting was supper was enjoyed. After the supper the meeting was called to order by the president, Mrs. M. J. Boggs, of Abbeville. Mrs. Hamilton of Abbeville, who has recently returned from Germany, gave an interesting talk on her stay there. After Mrs. Hamilton's talk a

business meeting was held to discuss the further organization of the Auxiliary. Mrs. W. G. Bishop of Greenwood, chairman of the constitution committee, read the constitution and by-laws written for our Auxiliary and it was passed by a vote to adopt the constitution.

MEDICAL AUXILIARY ESSAY CONTEST

The Woman's Auxiliary to the Columbia Medical Society is sponsoring an essay contest on "Why I Should Like to be a Nurse," which is open to all high school girl students in the tenth, eleventh and twelfth grades in the Columbia area. All essays must be in the hands of the contestants' respective high school Eng-lish teachers no later than Wednesday, February 25. They will select the two best papers from each school and submit them to the judging committee. The judges for the contest will be Mrs. W. P. Beckman, Mrs. Henry Plowden and Mrs. C. H. Epting. The essays menry Prowden and Mrs. C. H. Epting. The essays will be judged on sincerity, originality and neatness. The winner will receive a cash prize of \$10, and \$5 will be given for the second prize. The complete essay and picture of the successful contestant will be published later.

Mrs. Manly E. Hutchinson, president of the Woman's Auxiliary to the Columbia Medical Society stated that ten of the high schools have already been visited by committees from Columbia's four nursing Schools. Monday Mrs. Viana McCowan, head of the School of Nursing at the University, will address the students at Dreher High School on the nursing program. Others who have talked to the students are Miss

gram. Others who have tarked to the students are Miss Nan Eidson, Baptist Hospital; Miss Beulah Gardner, and Mrs. Autumn Ballentine of the State Hospital.

The Columbia Hospital is having a party from 4 to 6 p. m. Friday, February 13, for all high school students who are interested in nurse's training. Visitors will be taken on conducted tours through the buildings and will be given an opportunity to meet and converse with present graduate and student nurses. Members of the Woman's Auxiliary assisting the nurses as hostesses will be Mrs. David Adcock, Mrs. Kirby Mrs. Henry Plowden, Mrs. L. A. Riser, Mrs. Joe Freed, Mrs. R. L. Sanders, Mrs. Ben Miller, and the judges for the essay contest.

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The Inurnal of the

South Carolina Medical Association

VOLUME XLIV

April, 1948

Number 4

Charleston Panorama 1848-1948

It has been said that Boston is Massachusetts boiled down and Charleston is a very strong decoction of South Carolina. This was particularly true at the time of the organization of the South Carolina Medical Association, for Charleston was in all reality the center of life in the state, a center to which led an aggregate of 240 miles of railroad, a large range for any state at that time. The first line to the interior had been built in 1833 from Charleston to Hamburg, a distance of 136 miles. Highroads of dubious quality brought the produce of the upcountry to the only considerable port of the state, and state commerce centered its activities in the town.

In 1848 Charleston was crowded with a population of 26,451 in the city proper, exclusive of "the Neck." At that time the number of houses recorded to have been destroyed by several calamitous fires very nearly equalled the number then existing in the city. The water supply consisted of shallow wells and cisterns beneath the buildings and as a result scourges of mosquito borne disease were not infrequent. Nevertheless, in 1848 the city had been relatively free from its old enemy, yellow fever, for nine years. There had been no epidemic since 1839 after the great fire in the spring of 1838 when one-fifth of the city had been laid bare to fester. The worst was to come, but at this time the public health compared favorably with other cities of the United States.

This was a period extolled as the golden age of Carolina, when agriculture was glorified as morally superior to other less picturesque occupations, with resulting development of an aristocratic planter-dominated society. Cotton was undisputed king and there was a whole-hearted contempt for trade and anyone so engaged was the object of scorn by planters and professional men.

At this time Charleston was one of the busiest ports in America with its greatest activity dependent on the export of rice and cotton in enormous quantities. The code duello was in full force with its consequent malicious decimation of young manhood of the best class and the dueling ground at the Washington Race Course was often the scene of less happy occasions

than those gay affairs conducted by the Southern Jockey Club in its annual race meets.

The social season consisted of a giddy whirl of concerts, plays, races, operas, dinners, and dances climaxed by the St. Cecilia Balls. After a young lady had attended the last, discreetly chaperoned, she had been properly introduced to society. However, Charlestonians preferred entertaining at home with elaborate dinners and on the plantations with picnics and less formal dances.

Charleston by now had many charitable organizations, among which were the South Carolina Society, the Orphan House, the St. Andrew's Society, St. George's Society, the New England Society—all of which had long been in existence and survive to this day. The slave population required litle relief from public charities for in old age and decrepitude they became an expected charge upon the master.

Long before 1848 the abolitionist was an unbidden guest from a critical outside world and rumblings of rebellion were constantly audible. In this hotbed of threatened secession the foremost voice to be heard advocating the perpetuation of the Union was that of the eminent jurist and statesman, James L. Petigru. Despite his convictions, he was sincerely respected for his integrity and his eloquence and was invited by the Charleston Library Society to deliver an oration celebrating their first centennial in June, 1848. For all this, politics were ignored in the drawing room, not because ladies were supposed to be ignorant of them, for they rather cultivated a taste for public affairs, but because social occasions were deemed by southern gallants to be devoted to the diversions of polite society.

Charleston in 1848 had long had medical institutions. More than ninety years before it had a medical organization, the Faculty of Physic, and almost sixty years before it had founded a medical society, still in 1848 enduring, and seeking to expand the influence and service of medicine over the state and nation. Hospitals of sorts had been in use for many years—poor houses, hospitals for slaves, inoculation hospitals, marine hospitals, pest houses, even a Medical College



OLD MEDICAL COLLEGE, QUEEN STREET



ST. FRANCIS XAVIER INFIRMARY

Hospital, of brief existence, and Roper Hospital was about to open its doors in Queen Street. The Shirras Dispensary had long been in operation. Two medical colleges had developed, fought, and merged amicably long before 1848. The beginning of this educational growth had already been twenty-five years past. The Medical Society possessed then a library of nearly 2500 volumes, available to the student as well as to the regular member; and members of the profession were known nationally for their worth and technical ability. The Charleston Medical Journal enjoyed a wide and favorable reputation, and many other substantial medical publications had come from the city in years just past.

Many of the landmarks of a century ago are no longer with us for in 1861 another disastrons fire swept diagonally across the lower part of the city almost from the Market to the Ashley River. During the War Between the States, Charleston was under bombardment for over 500 days and in 1886 was visited by a severe earthquake which seriously affected every building it did not destroy—with the one exception of the Fireproof Building which is an honest tribute to the architect, Robert Mills. Various storms, hurricanes, and a tornado in 1938 have taken their toll. Despite reverses and disasters, both mundane and divine, a great part of old and historic Charleston remains and it is the endeavor of the populace to keep it intact.

A hundred years have gone by since the Medical Society of South Carolina called the convention which resolved itself into the South Carolina Medical Association. Charleston has suffered war, fire, earthquake, tidal wave, tornado and the repeated buffeting of hurricanes, vet much remains of the physical cradle of the Association. Much has been preserved, casually or carefully, and much has been done to curb the promiscuous growth of unsightly "modern" buildings whose chief claim to fame and form is a window of an odd shape or a shiny color of a queer huc or a painfully functional design approaching the shoebox. In spite of such efforts, the city is speckled with a fair supply of unpalatable buildings, garish movic houses, and concrete-block barns, nudging and frequently toppling many fine old structures, which have been cut off from their kind by the constantly changing tide of business districts. The old peninsula has become too cramped, and residential districts have spread up the neck of land, and crossed the rivers and taken to the islands to become flourishing communities. The North Charleston area, with the Naval Base and

industrial developments, has become almost as populous as Charleston proper, and the port of Charleston extends far up the Cooper River. Shipping is increasing, and the harbor is busy. Four radio stations dispense a great deal of information and a great deal more nonsense, and two theater groups supply a round of well produced entertainment and stimulation.

Once the capitol of the plantations of the surrounding territory in matters of commerce and shipping, Charleston now retains the title largely in a social way, for the plantations have become preserves and pleasure grounds rather than producers.

In medicine, Charleston has seen its onetime unique position in the state change considerably. Once there was a time when patients came from all sections of South Carolina to see the Charlestonian physicians of wide reputation, or the Charleston doctor travelled far to perform the operations for which he alone was considered qualified. Now with the growth of good hospitals throughout the state, and the improvement of medical facilities in general, it is not necessary that patients travel far for aid in the great majority of medical and surgical difficulties. Charleston still can boast of having Roper Hospital, the largest general hospital of the state, recently improved by a fine new private wing, and well equipped professionally by virtue of its association with the Medical College. The College, enlarged and expanded has long moved from its old location and is proceeding with an extensive program for building a fine new College Hospital, to be administered by the faculty and paid for by the state. This institution will offer facilities of diagnosis and treatment to patients from all over South Carolina.

Other hospitals in the Charleston area are the St. Francis Xavier Infirmary, the Baker Sanatorium, the Hospital and Training School (negro), a fine new Naval Hospital, Pinehaven Tuberculosis Sanatorium, and the U. S. Quarantine Station. Residents of the North Charleston section are hoping to have a new hospital before long.

The standard of medicine in Charleston has always been held high. The efforts of the profession of a century ago have borne fine fruit in the active and influential Association which now returns to its birth-place to celebrate its accomplishments of ten decades—A mutual pride of accomplishment should create the amiable atmosphere of this coming meeting.



OLD ROPER HOSPITAL



NEW ROPER HOSPITAL

Acute Porphyria

RALPH R. COLEMAN, M. D. Charleston, S. C.

Porphyria is an unusual disturbance of pigment metabolism in man due to an inborn metabolic fault. It is characterized by the passage of reddish brown or wine-colored urine, and patients affected by the disease present a group of symptoms referable to the skin, central nervous system or gastro-intestinal tract.

The porphyrias are usually classified by most authors into congenital, acute and chronic porphyria.

Congenital porphyria is characterized by its appearance early in life, the excretion of large amounts of uroporphyrin I in the urine, photosensitivity, a predominance in males and is probably transmitted as a mendelian recessive. The outstanding clinical features are the development of bullous or erythematous skin lesions after exposure to sunlight and pigmentation of the teeth.

Acute porphyria is in reality a chronic condition with exacerbations and remissions over a long period of years. A history suggestive of family occurrence can generally be obtained. The disease does not as a rule make its appearance early in life, photosensitivity is rare or absent, it is more common in the female and is probably transmitted as a mendelian dominant. The outstanding clinical features are abdominal pain, neurologic disturbances, and passage of Burgundy wine-colored urine containing large amounts of uroporphyrin II.

It is the purpose of this paper to call attention to the clinical features of the disease and to present a case which was followed recently.

Patients with acute porphyria probably have assorted complaints from time to time referable to their disease. These may include vague and poorly localized pains in the abdomen and extremities, insomnia, irritability, mental depression, the passage of dark urine and weakness.

The acute episode may be precipitated by certain drugs and toxic agents, among those mentioned in the literature are lead, acctanilid, nitrobenzol, sulfonal, trional, the barbiturates and perhaps sulfanilimide. Many bizarre and confusing clinical pictures have been described. The symptoms are generally referable to the gastro-intestinal tract and central nervous system. There is usually severe, generalized, cramping abdominal pain, nausea, vomiting and constipation. Jaundice sometimes occurs. The central nervous system symptoms include pain, paresthesias and paralyses, epileptic seizures, coma, delirium and even mania. An ascending or Landry's type of paralysis is often seen. All types of psychotic behavior may occur. In many cases without objective findings, a psychoneurosis is suspected. Amenorrhea commonly occurs. Hypertension is also very frequent in the acute cases and may curiously alternate with hypotension. Transient changes in the electrocardiograph consisting of elevation of the S T segments occur during the acute episodes. Leukocytosis up to 20,000 W.B.C. is generally present.

The differential diagnosis will obviously offer many difficulties. With abdominal pain, nausea, vomiting and leukocytosis, mistaken diagnoses of acute appendicitis, cholecystitis, intestinal obstruction, ovarian eyst (torsion or rupture) have been made and unnecessary operations performed. Because of the amenorrhea, pregnancy is suspected and with the onset of violent abdominal pain, the diagnosis of ruptured tubal pregnancy is ofttimes made. The neurological signs are confused with infectious polyneuritis which includes the Guillain-Barre' syndrome and other peripheral neuropathies. Other neurologic entities with which the condition may be confused are encephalitis, brain tumor, poliomyelitis, progressive muscular atrophy. Hysteria, malingering and the various psychoneuroses are also suggested. The disease may also mimic periarteritis nodosa, trichinosis and hypertensive encephalopathy.

The diagnosis of acute porphyria depends upon recognition of the clinical picture and upon demonstration of uroporphyrin in the urine on spectroscopic analysis. Watson and Schwartz have devised a single chemical test for urinary porphobilinogen which they believe to be pathognomonic for porphyria. The passage of wine-colored or apparently bloody urine in which no blood cells are found should arouse suspicion. Exposure of half of the specimen to the sunlight to determine the presence of photosensitive substances can easily be carried out. If deepened color appears, the presence of uroporphyrin is to be suspected and spectroscopic analysis should be done.

The cause of the various symptoms is not known. Chemical effects of the porphyrins upon the cells of the central nervous system is one mechanism mentioned. The hypertension is thought to be due to angiospasm.

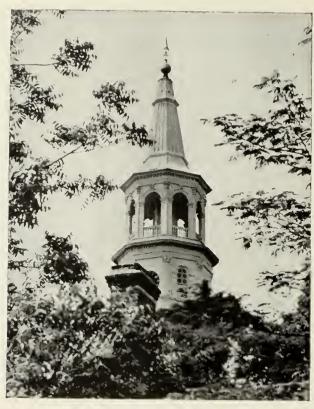
The pathologic findings are variable and often disappointing. These are described by Mason, Courville and Ziskind.

PROGNOSIS:

The prognosis during the acute attack is poor with a mortality rate up to 90 percent. However, after the first appearance of the disease patients have been followed up to twenty-seven years.

TREATMENT:

There is no satisfactory or specific treatment. Strong sunlight should be avoided in the occasional case in which photosensitivity has been demonstrated. Strict



ST. MICHAEL'S CHURCH STEEPLE



AERIAL VIEW OF CHARLESTON

avoidance of the barbiturates and the other known chemical precipitating factors should be practiced. Cases with neurological involvement should be watched for bulbar weakness and a respirator should be available.

REPORT OF CASE

A twenty-one year old white female was taken acutely ill on January 5, 1946 with nausea, vomiting and generalized cramping, colicky abdominal pain. Several hours prior to onset, during a train journey she had ingested a tomato stuffed with tunafish and spoilage was suspected. The menstrual period was three days overdue and she stated that she noted some breast fulness.

Physical examination on the morning after onset revealed a blood pressure of 130/70, temperature and pulse readings were within normal limits. The state of hydration was good. The head and neck were negative to physical examination. The lung fields were clear throughout to auscultation and percussion, and the heart was not remarkable. The abdomen was slightly tender to deep palpation in both lower quadrants, peristalsis was hyperactive but there was no muscle spasm, rigidity or point of localized tenderness. Pain coincided with the easily audible peristaltic rushes.

A tentative diagnosis of acute gastro-enteritis and possible early pregnancy was made at this time and symptomatic therapy was carried out.

For the next three days she continued to have intermittent bouts of severe cramping abdominal pain without localization. On occasion she obtained almost complete relief from enemata. In the carly morning of January 10th the abdominal pain became progressively severe. At 8:20 A. M. she suddenly experienced a convulsive seizure during which she exhibited opisthotonos, generalized clonic movements, and frothing at the mouth, lasting several minutes.

Physical examination at 9:30 A. M. revealed a thready pulse with a rate of 130; blood pressure was 100/70 but gradually rose to 130/70. The abdomen was soft, relaxed and only moderately tender in both lower quadrants, principally to the left. In view of the fact that the menstrual period was now at least seven days late, the severe pain followed by vascular collapse, a ruptured cetopic pregnancy was suspected and an obstetrical consultant was called in. (Dr. A. L. Rivers).

Hospitalization was decided upon and she was admitted to Riverside Infirmary on January 10, 1946. Pelvic examination shortly after entry revealed a slightly enlarged and questionably softened uterus in mid-position and no masses in either fornix. The blood counting revealed a total leukocyte count of 14,700 with 78% poly's. The R.B.C. was 4.7 million with 12 gms of hemoglobin. The urine was described as "orange" colored but was negative for albumin, sngar and to microscopic examination. The blood pressure after hospital entry was found to be 170/120

and the pulse rate ranged between 120 to 130.

Re-examination of the abdomen after four hours revealed localizing tenderness in the right lower quadrant and surgical consultation was asked. (Dr. F. G. Cain)

Exploratory laparotomy was deemed advisable and this was carried out under general anesthesia (dropether). At operation the appendix was found to be kinked by congenital adhesions to the caecum and was somewhat thickened. The uterus was slightly enlarged and softened but both tubes and ovaries were entirely normal. No other evident cause for the abdominal pain was found. During the operative procedure, the blood pressure averaged 150/110. The blood pressure readings in the subsequent ten day period ranged from 188/120 to 145/110.

POSTOPERATIVE COURSE:

During her postoperative course she began to complain bitterly of severe migratory abdominal and back pain. The abdomen remained soft and nontender to palpation and there were no other physical findings to explain her pain. Opiates were withheld on January 11th, 1946 and phenobarbital sodium in gr iii doses were substituted and she received a total of 15 grains in the next 28 hours. Repeated blood pressure readings were made during this time and there was no change while in deep sleep. On January 12th the urine was noted to be grossly bloody by the nursing staff, however this specimen was inadvertently discarded. A repeat specimen (catheter) orange in color, contained no red blood cells on microscopic examination. The ophthalmoscopic examination revealed a normal eyeground picture at several examinations during this time. Fluid intake was maintained at the minimum of 4000 c.c. for each twentyfour hour period. A Freidman test was performed on January 21, 1946 and was later reported to be positive. Cystoscopy and retrograde pyelography was done on January 29th revealing normal pelves and calvees. Indigocarmine dye function was good from both kidneys. The migratory back and abdominal pain gradually diminished in severity and she was discharged on January 29th.

SUBSEQUENT COURSE:

The blood pressure readings after hospital discharge averaged 140–90. A specimen of urine obtained one week later was amber in color. Thirty minutes after exposure to sunlight the color had changed to deep mahogany. Repeat examinations revealed the same phenomena. Spectroscopic analysis revealed the characteristic wave band for uroporphyrin HI.

The patient now stated that the passage of highlycolored "orange" nrine was of frequent occurrence for a period of several years. This was assumed to be normal and was unassociated with any symptoms. In addition, the details of her mother's illness were



DOCK STREET THEATRE

obtained through correspondence. It is of interest to note that there were repeated laparotomies for unexplained abdominal pain and that at one operation "the left tube and ovary were removed for possible tubal pregnancy." She likewise had unexplained convulsive seizures, severe abdominal and back pain, atony of the gastro-intestinal tract and menstrual disturbances. Her death was attributed to a bronchopneumonia complicating a laparotomy (the fourth) because of right lower quadrant pain and abdominal distention.

The pregnancy proceeded to the eighth month of gestation without incident. Painless, profuse vaginal bleeding was noted on August 28, 1946 and examination after admission to the hospital revealed a central placenta praevia. A healthy male infant was delivered by Caesarian section (Dr. Rivers). The post-operative course was entirely satisfactory. No barbiturates were used on this hospital admission, and demerol was used for relief of discomfort. Two (500 c.c.) blood transfusions were given without untoward reaction. The patient's urine during this time was highly colored and exposure to sunlight produced a prompt and marked color change to a deep brownish-red. No quantitative measurement of urinary porphyrin was made. The infant's urine was examined and found to be free of porphyrin pigments.

The last physical examination was made on June 18, 1947, at which time the patient was in good health and entirely symptom-free. There were no abnormal physical findings. The urine, as before, continued to show the same photosensitive material.

COMMENT:

Porphyria and Pregnancy:

Linas, Solomon and Figge reported the first case

of chronic porphyria complicated by pregnancy. During the pregnancy there was exacerbation of the skin lesions and an increase in the amount of porphyrin excretion. They concluded that porphyria would not appear to be an indication for the interruption of pregnancy.

The case presented would add to the accumulating evidence on this subject. Her pregnancy and puerperium were entirely normal and Caesarian section was well tolerated. The infant was in good condition and has continued to be healthy. No uroporphyrin was found in the infant's urine.

SUMMARY AND CONCLUSION

The clinical features of acute porphyria and a case illustrating these features is presented.

Pregnancy and delivery by Caesarian section occurred without incident in this case.

Porphyria does not constitute an indication for the interruption of pregnancy.

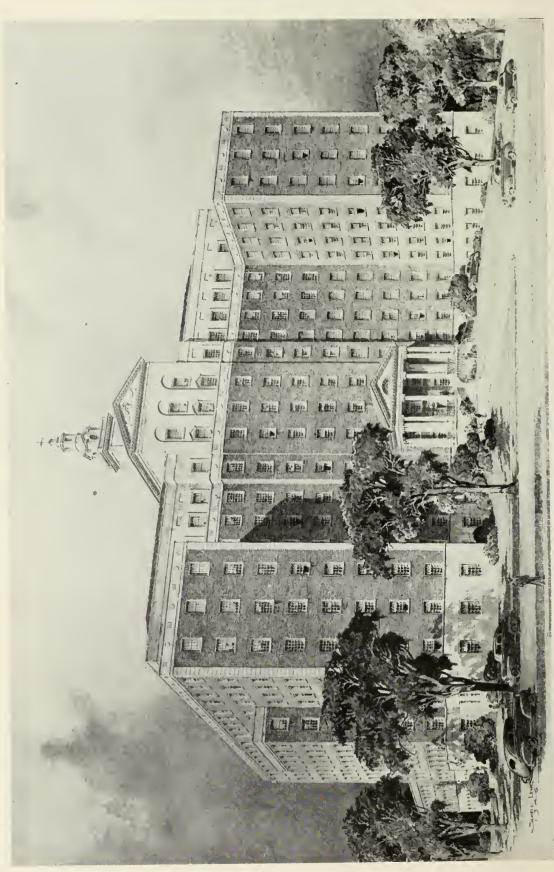
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Carcinoma of the Terminal Heum A Case Study

KARL MORGAN LIPPERT, M.D., F.A.C.S., F.I.C.S HENRY POTOZKY, M.D. LEWIS E. NOLAN, M.D., F.A.A.P., F.A.S.C.P. Veterans Administration Columbia, S. C.

A carcinoma originating in the terminal ileum is an extreme rarity and its characteristics so inconstant that a careful study of each case is warranted. Probably there could be no better introduction to the presentation of the case to follow than is contained in the opening paragraph of Dr. Charles W. Mavo's paper concerned with malignancy of the small intestine in which he says: "Fifty-five verified cases of carcinoma of the small intestine encountered at The Mayo Clinic were reviewed in 1929 with the purpose of determining whether the clinical findings were sufficient to justify a preoperative diagnosis of such a lesion. Up to that time the eventual diagnosis usually had come as a surprise to both the physician and the surgeon. Since that time, the 'batting average' of accuracy, although not perfect, has increased appreciably. This has been due not only to care in examination and in eliciting a careful history but also to progress in roentgenologic methods used in examining this portion of the intestinal tract." One interested in malignancies of the small bowcl could not do better than to review this paper and also another very comprehensive study of Carcinoid Tumors of the Ileum by Dockerty and Ashburn,7 in which carcinoid has, because of its pathologic characteristics, been classified as a Grade 1 (Broders) carcinoma, particularly because of its frequent invasive and metastatic tendency,

Perusal of those cases of small bowel neoplasm in the literature1 indicates that they are least likely to occur in the last portion of the ileum. One case2 of adenocarcinoma of the terminal ileum with a descriptive similarity to the one reported here has been noted, Apparently, most of the small bowel neoplasms benign and malignant, have been discovered as result of obstructive symptoms although there are some cases which have been confused with inflaminatory lesions. In the differential clinical diagnosis of a malignancy of the terminal ileum, one would have to eliminate the diseases affecting Peyer's patches and the mycotic infections; however, the more frequent inflammatory conditions with which one would be concerned are tuberculosis and regional enteritis. The latter has been further defined as "terminal ileitis," "cicatrizing enterocolitis" and "segmental or right sided colitis." The malignancy which we report, as seen at the operating table, was so associated with inflammatory reaction that it was believed to be a type of regional enteritis. It is interesting to note that of those cases of small bowel malignancy reported weakness, fatigability and anemia were cardinal findings and yet these same signs and symptoms are so often recorded in cases of chronic regional enteritis. The therapy of regional enteritis has been largely conservative. Some recent articles, Garlock and Crohn, 3 Colp4 and Kiefer and Ross, 5 on the diagnosis and treatment of the various types of regional enteritis give the impression that in the average case medical treatment is sufficient and that where surgery becomes necessary a simple ileo-colostomy and defunctionalizing of the distal ileum is all that is necessary.

The occurrence of a case in this Veterans Administration Hospital, having a elinical history and physical findings not distinguishable from those of regional enteritis, and yet which proved to be a highly malignant carcinoma of the terminal ileum, is being reported because it may serve as a reminder that lesions having similar characteristics, in this portion of the small bowel, may require entirely dissimilar therapy.

Case Report. F. L. No. 51 337. A 28 year old, married, white male entering this Veterans Administration Hospital March 10, 1947, complaining of weakness and fatigability. He had entered the Army in July, 1944, and after beginning the rigorous physical routine of training he noticed that on exertion he was easily fatigued and had palpitation of the heart and also that he occasionally vomited about breakfast time. He often had lower abdominal cramps and his lower abdomen was always sore on pressure. This state of health continued until he was hospitalized as being "extremely nervous." Later be was given a CDD from the Army in December, 1944, because of what the patient called a "nervous stomach." During this period of study in the hospital there was no history of hematemesis, and tarry or bloody stools were not noted. His weight had remained about 160 pounds. After leaving the Army his health improved for a time but when he went to work the tendency to fatigue became progressively worse. He noted also that a vague abdominal discomfort appeared frequently, This discomfort had no relationship to food taking but at some times it seemed most prominent in the upper abdomen. He was hospitalized in the veterans section of Fort Jackson Hospital and there he learned that his blood count was 2,500,000 and hemoglobin was 5.5 grams. No diagnosis was given at that time but patient was told he had been losing blood by

rectum and had become anemie. He was advised to take iron capsules and was dismissed from the hospital to the care of his own physician. Apparently the iron therapy caused an increase in abdominal discomfort and he noticed that his stools became very black in color. His private physician discontinued the capsules and in turn gave him iron and liver "shots." The stools were said to have promptly returned to normal color after discontinuing the iron by mouth but the patient's general condition did not improve and during the three weeks prior to admission to this hospital he lost fifteen pounds in weight.

According to the past history the patient had an appendectomy in 1939 for an attack of abdominal cramps and vomiting. He remained free of abdominal discomfort until he entered the Army. As a child he had the usual childhood diseases without sequelae. It was found that one brother was treated for "ulcerated stomach" and another was quite anemic at the age of twelve; both recovered under therapy.

Physical examination on admission to this hospital revealed a young, undernourished, pale, white man, who appeared to be more chronically than acutely ill, weighing 136 pounds. Examination of the various systems failed to reveal any outstanding abnormalities except as follows: The liver and spleen were palpably enlarged but not tender; the blood pressure was 152/95. The initial blood count showed red blood eells 4,000,000; hemoglobin 10 grams, with eolor index of 75 and hematocrit 26. The white blood count was within normal limits and no significant departure from the normal distribution percentage of leucoeytes. The stools showed a consistent three to four plus occult blood. The blood count soon fell to 3,500,000 red blood cells with 9.8 grams hemoglobin. Urea nitrogen was 17 milligrams per cent. Cephalin flocculation was negative in 24 hours but three plus in 48 hours. Mosenthal concentration test was normal. PSP showed slight retardation in output.

The radiological study of the GI tract revealed an extensive lesion of the distal ileum. The process was eharacterized by marked alteration in the mncosal pattern of the bowel. There were diffuse polypoid changes in the fleum and in one area a well defined filling defect was noted (Figure 2). There were infiltrations and indurations of all coats of the intestinal wall with absence of peristaltic activity in the involved region. It was difficult to estimate the extent of the lesion although it appeared that about eight inches of the ileum was involved. The terminal ileum showed no mucosal changes although it was matted and adherent to the medial border of the cecum. This produeed an extensive deformity of the medial border of the cecum, best seen on the evacuation film following barium enema (Figure 3). There was no definite



Figure 2
Illustrates a filling defeet in the terminal ileum associated with irregular narrowing and deformity of a long segment of terminal ileum.

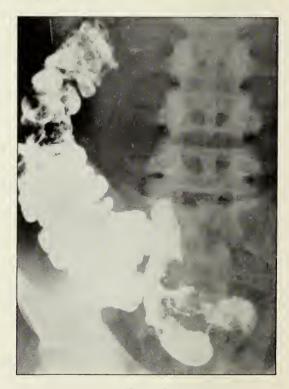


Figure 3 Illustrates the extensive deformity of the medial border of the cecum.

change in the mucosal pattern of the cecum nor was there any evidence of intrinsic cecal disease. * See Footnote.

It was generally agreed that surgical exploration was indicated and the patient was rapidly prepared for operation by multiple blood transfusions, a high protein and vitamin diet, with snlfasuxadine to chemically sterilize the intestinal tract.

On April 28, 1947, through a right flank incision (Figure 1) and under spinal anesthesia the abdomen

of the colon up to the mid-transverse portion was included in the resection. An end-to-side ileo-colostomy was performed after closure of the distal end of the divided transverse colon.

The postoperative course was relatively uneventful except for tarry stools for a few days, the source of the blood apparently being from the raw surface of the bowel at the site of anastamosis. This patient has been up and about ever since approximately three weeks from date of operation. Latest follow-up report



Figure 1
Right flank incision recommended for resection of the cecum and right colon.

was explored. A mass composed of the last 18 inches of the small bowel, adherent to the cecum, pelvic peritoneum and to itself in convoluted loops, was delivered. In attempting to free the bowel the intestine was broken into but the perforation was quickly sealed by suture. Because of the unusual appearance of this grossly inflammatory mass, a wide excision was done, leaving a normal interval of ileum distal to the point of division of the small bowel. All

° (Footnote:

Having given a lesion with the characteristics enumerated above, how far can we go in establishing a pathological diagnosis? Actually, we do not believe that, from a radiologic viewpoint, an exact dillerential diagnosis can be made between inllanunatory disease and neoplasm. The absence of stenotic changes is somewhat difficult to explain if we are dealing with a granulomatous process such as regional enteritis. However, sufficient cases of non-stenosing ileitis have been placed on record to make this an unreliable diagnostic criterion. The polypoid changes of the mucosa have been stressed and this might incline one to favor the diagnosis of neoplasm. Actually, however, granulomatous masses and secondary polypoid changes of the mucosa as result of long standing inllammatory disease could produce the same type of mucosal pattern. Ultimately, therefore, the differential diagnosis must rest with the pathologist.)

is that he is asymptomatic and has gained weight almost to a state of obesity. The patient was referred to a radiologic center for opinion as to postoperative roentgen therapy but none was advised at this time.

PATHOLOGIC EXAMINATION OF SPECIMEN REMOVED

MACROSCOPIC: The specimen consists of a resected segment of the ascending colon, cecum and terminal ileum. The appendix is absent, having been removed in 1939, according to the history. The cecum at the site of the base of the appendix is smooth; the segment of colon measures 21 cm in length and inchides the cecum and, the ileo-cecal valve. The resected segment of terminal ileum attached to the cecum measures 28 cm. There is no thickening of the wall of the colon and the mucosal pattern is normal. There is a diffuse thickening of the terminal ileum originating 8 cm above the ilco-cecal valve and extending proximally a distance of 12 cm. The mucosal pattern has been distorted, obliterated and ulcerated throughout the extent of the tumor mass. The segment of ileum containing the tumor is adherent to adjacent resected segments of ileum. There is 8 cm of uninvolved ileum above the region of the tumor and 8 cm of ileum which appears normal and free from tumor tissue below the mass. Cut section through the wall of the ileum in the area of involvement shows a marked thickening of the inner layers of the bowel



Figure 4
Gross , appearance of the open terminal ileum demonstrating the infiltrating character of the adenocarcinoma.



Figure 5

Photomicrograph of adenocarcinoma of the terminal ileum. Note infiltration of the wall of the ileum by imperfect alveolar segments and irregular masses of atypical, hyperchromatic oval and low columnal epithelial cells.

wall which consists of homogeneous white tissue which cuts with slightly increased resistance. There are several small lymph nodes distributed along the colon, which measure from 0.4 to 0.6 cm in diameter.

MICROSCOPIC: The sections show irregular masses of atypical epithelial cells with an imperfect glandular arrangement replacing the mucosa and extensively infiltrating the sub-mucosa and tunica muscularis. There is complete loss of polarity. The tumor cells are mostly cylindrical in shape, rather large and vary considerably in size. The cystoplasm takes an irregular pale to dark acidophilic stain with Haemotoxylin-cosin with areas of vacuolization and hydropic degeneration. The nuclei are large with prominent macronucleoli and have a thick, deeply basophilic chromatin network. Occasional cells in mitosis are seen. One section shows relatively normal mucosa with nests of tumor cells invading the underlying submucosa. The submucosa also contains small nests of tumor cells. The lymph nodes are not involved. The stroma is infiltrated by scattered small round cells and polymorphonuclear neutrophilic leukocytes. Diagnosis: Adenocarcinoma, Grade III (Broders) terminal ileum.

SUMMARY

- 1. Malignant tumors of the terminal portion of the small intestine are extremely rare.
- 2. Such diseases as "regional enteritis" or "cicatrizing entero-colitis" and "segmental or right sided colitis" present the greatest obstacle to clinical diagnoses, and proper treatment of carcinoma of the terminal ileum.
- 3. A case of carcinoma of the terminal ileum is presented with photographic illustrations of the X-ray and pathologic findings.

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Director, Department of Medicine and Surgery, Veterans Administration, who assumes no responsibility for the opinions expressed or conclusions drawn by the author.

Mental Hygiene Clinic in Spartanburg

J. M. PRATT, M. D. Hickory Grove, S. C.

I would like to discuss briefly with you tonight the "Organization and Objectives of the Spartanburg Mental Hygiene Clinic," enlightening you on the law in which Congress authorized the establishment of this clinic, and other provisions of the law. Then to discuss personnel and the workings of the clinic, especially endeavoring to familiarize you with the plans and methods we hope to utilize in solving the problems of mental health which will be referred to the clinic. I should like to pause here to state that I enter upon my duties with this clinic in the hope that its workings will be an adjunct to the members of this society, in endeavoring to sustain optimum health of the citizens of this community. I fully appreciate the fact that the health of our community is the responsibility of the members of this society. It is needless to remind you that there is no separation of the mental and physical health of an individual, because it requires a wholesome integration of the two to make an individual a well-motivated and productive person.

I was impressed, upon first learning of the clinic, with your awareness of the necessity for the program, as shown by your appointing a member of your society as a member of the advisory committee to the clinic.

A mental hygiene clinic for Spartanburg and the surrounding area is not a new thing. Several years ago, under the auspices of the South Carolina State Hospital, a clinic was held here two days of each month, a member of the medical staff of the South Carolina State Hospital being assigned to the out-patient service. This clinic was held in six of the largest towns of the state; Spartanburg, Columbia, Charleston, Rock Hill, Anderson, and Florence. This ont-patient service of the State Hospital, by sheer necessity, had to be discontinued at the outbreak of the last war because of the shortage of personnel. The service was a credit to Dr. Williams, then Superintendent, as he foresaw the necessity of a program of early diagnosis and prevention of mental aberrations. The out-patient service, as many of you will recall, was very beneficial, although there were available only 75 hours, or 2.5% of the estimated need. The National Committee of Mental Hygiene has estimated that 2880 mental hygiene clinic hours will have to be made available before an adequate mental hygiene clinic program will reach its optimum effect.

I am informed that for a number of years, through the interest and initiative of certain laymen, especially those active in local mental hygiene society, and you physicians, the idea of establishing a locally supported hygiene clinic here has been considered. To the satisfaction of all interested parties, local support was found to be unnecessary when Congress, on July 3. 1946, passed the National Mental Health Act. This Act resulted largely from the experience of World War II, in which it was found that an appallingly large number of American youth had to be rejected, or later discharged, or subsequently hospitalized because of mental aberrations. And, too, the need of such an Act is brought home to us when we realize that one in every ten persons in our country is affected with some form of mental aberration, one out of every twenty is hospitalized because of mental disease. Most of us do not appreciate the fact that there are seven times as many people hospitalized with one particular type of mental disease, schizophrenia, than are hospitalized with tuberculosis; that half of our hospital beds are occupied by mental disease cases, and that during the last war one out of every seven selectees was rejected because of mental disease. Repeated surveys of the hospitals in which I served during the last war revealed that approximately 33% of the patients were hospitalized because of mental disease. This figure, in general, was consistent with all hospitals serving military personnel. So you see there is a need for steps to correct such a state of affairs.

The National Mental Health Act authorized the establishment of certain functions within the United States Public Health Service, and also authorized certain expenditures in the performance of these functions. Since the passing of the so-called New Deal, some may wonder if this law may not be forgotten as many other laws of the same period will certainly be. Of course, no one can speak with authority, but those in position to know think that since the Bill was of a bi-partisan nature, guided through to passage on the floor of the House of Representatives by Clarence Brown of Ohio, and in the Senate by Senator Robert Taft, the measure will survive, and that the incoming Congress will make

This paper was read before the Spartanburg Medical Society at its January 1948 meeting.

adequate appropriations to sustain the movement.

I am sure that you, as physicians, are interested in knowing the limitations of benefits that may be anticipated for the state, as a whole, for various social and welfare organizations, and more particularly, for the individual ease. The main aspects of the program as planned are: (1) research concerning the problems of mental health, (2) training of personnel in various mental health specialty fields, and (3) support and stimulation of the efforts by the state to develop adequate mental health programs, particularly with respect to the preventive phases of the work.

With regard to research, the Bill specifically authorizes expansion and development of research into causes, methods of diagnosis, treatment and prevention of psychiatric disorders. In the past, the research in the field of mental health has lagged far behind investigation in other fields of medical science. I feel that if we knew the etiology of that dreaded disease, schizophrenia, we could treat it more effectively and, perhaps, eventually lower the incidence of that type of mental disorder. The Act provides for research to be accomplished in three ways. (1) Research can be supported by providing grants-in-aid for research to Universities, laboratories and other public or private institutions, and to individuals. The research projects must be approved by the National Advisory Mental Health Council. The Council consists of a group of six individuals, selected without regard to civil service laws from leading medical and scientific authorities, who are outstanding in the study, diagnosis, and treatment of nervous and mental disorders. Dr. William Menninger, the Army's ehief neuro-psychiatric consultant during the last war, is a member of the Council, This Council advises the Mental Hygiene Division of the United States Public Health Service along many lines.

Secondly, the law authorizes the construction of a research and training center in the Washington area, to be known as the National Institute of Mental Health. This unit is to house 200 special cases. One of the first investigations to be undertaken is "What Part Does Heredity Play in the Development of Mental Disorders." At the present time only two mental disorders have definitely been proved to be interlinked with heredity. They are, namely, epilepsy and mental deficiency.

Thirdly, the law provides for the appointment of research fellows in various scientific fields that bear upon mental health. The training phase of the program will be directed towards relieving the acute shortage of trained personnel in the mental health field. It is estimated that the U. S. should have 10,000 psychiatrists. Actually, we have only 4,500. During the early part of the last war there were only 3,500 psychiatrists, and of this number, 1,000 were in the armed forces. So you see there was a pathetic shortage of psychiatrists both in civilian life and in the armed

forces. It is estimated that we have only 25% of the clinical psychologists, 25% of the psychiatric nurses, and 20% of the psychiatric social workers needed for an effective program. I understand there are only 1,400 of the latter group in this country, and I would like to state that three weeks ago we were successful in inducing one of the best trained of these social workers to join our staff. She is Miss Bumstead, who is a graduate* of the New York School of Social Workers and has spent her entire life in psychiatric social work, having had extensive experience in child guidance work.

The phase of the program in which we are especially interested is mental hygiene. Since the enactment of the law the United States has been divided into districts. South Carolina is in the second district, with headquarters in Richmond, Va. The district headquarters is headed by a public health psychiatrist, Dr. Southard, a soft-spoken North Carolinian, who has been most willing and cooperative. At no time has he dictated how our clinic should be organized or run. At the outset the program required each state to designate a State Mental Health Authority. This individual or agency was required to submit a plan and budget, covering the entire state, for approval before he would be allotted the funds to establish the state's mental hygiene program. The amount of funds granted to each state is based upon the following three factors: population, financial needs. and the extent of the mental health problem. In most of the states, the State Public Health Service is charged with the responsibility of establishing and conducting the program. In some states the Department of Public Welfare has been designated. In South Carolina, the Superintendent of the State Hospital has been designated the state authority.

The national program proposes to establish separate full-time mental hygiene clinics in each community of 100,000 in population, or more, and for smaller communities, traveling units sufficient in number to care for the needs. In addition, it is proposed to maintain a central or administrative center, through which the work of the clinics will be directed and coordinated.

The central administrative office for South Carolina is located at the State Hospital in Columbia. Dr. Coyt Ham, Director, plans to establish five clinics in South Carolina similar to the one here in Spartanburg. At present, there are only two in the state. The first to begin functioning was the one in Charleston, headed by Dr. Olin Chamberlain, in conjunction with the Medical School. Ours here is in its infancy, but I feel reasonably sure it is soon going to assume the characteristics of a matured, well-coordinated, smooth-functioning clinic. I want to assure you that the success of this clinic depends more than anything else upon the cooperation given it by you of the medical profession. I plea for your cooperation and understanding, and would like to state that perfection is not

anticipated by those of us connected with the clinic. Instead, through our sustained and diligent efforts, we hope to aid and assist the patients to improve their motivation and their ability to adjust to the exigencies of life. Of those afflicted with mental aberrations, there will be patients, especially some of the alcoholics, constitutional psychopaths and schizophrenics, whom we will aid little, if any, by our service. However, I feel reasonably sure that the larger percentage of our patients will be aided by our service.

The clinic's personnel will consist of myself as director-psychiatrist; Miss Bumstead as chief psychiatric social worker, who will from day to day be in charge of administration; a part-time clinical psychologist, who has yet to be selected; and Mrs. Manidell Connors, as secretary. In the very near future we hope to acquire the services of a junior social worker and later, if necessary, a psychiatric nurse. Starting February 15th, Miss Bumstead and Mrs. Conners will be at your service daily, and one psychologist, as needed. I am at the present time devoting the entire day of Thursday to the clinic and hope that in the near future I can give more time to it. Ferreting out psychodynamics and following through with the proper psychotherapy in mental disease is time-con-

suming and requires a high degree of patience, especially as regards psychoneurosis and behavior problems of children. In order to accomplish much in the treatment of a mental disorder, one must, as in physical diseases, properly determine the etiology of the condition. We plan first to diagnose our cases and then to utilize all the modern psychiatric, therapeutic procedures, namely psychotherapy, occupational therapy, correction of ill-family and environmental factors, and narco-synthesis. I am considering instituting shock therapy, also, I should like to state that we are going to be alert to early neurological disturbances that may make their appearance in our work. As you know, in incipient stages, symptoms of neurological and psychiatric diseases are quite similar.

In summary, we have discussed the National Mental Health Act as passed by the 79th Congress, giving the main aspects of the program as planned with respect to the nation at large, as well as to the organization and functioning of the State Mental Hygiene Clinics. We have also tried to explain the manner in which personnel of the local mental hygiene clinic will be utilized in solving the mental problems encountered in Spartanburg and its surrounding areas.

-HOTEL RESERVATIONS-

The Francis Marion Hotel is headquarters.

The Fort Sumter Hotel is available, as are the Charleston Hotel and the St. John's Hotel.

The Daniel Ravenel Co., Travel Agency, 54½ Broad St., Charleston, can handle reservations for hotels and rooms in private homes and also arrange tours of the city and gardens.

Members unable to obtain reservations should communicate with Dr. H. G. Smithy, Medical College, Lucas St., Charleston 16, S. C., and state expected time of arrival and departure.

"Members of the International College of Surgeons will meet to organize the S. C. Chapter, Wednesday, May 12, 1948, during the lunch hour, the meeting to be held at Henry's unless otherwise announced.

The members of the State Committee for fractures and other trauma of the American College of Surgeons will be held Wednesday evening at six o'clock during the dinner hour at Henry's. The meeting will end in ample time to attend the performance at the Dock Street Theater."

SOUTHERN PEDIATRIC SEMINAR

28TH SESSION

MEETS JULY 5 - JULY 17, 1948

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Frank Howard Richardson, M. D., Vice Dean
Mylnor W. Beach, M. D., Vice Dean Elect

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Durham, N. C.

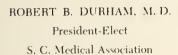
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OLIN B. CHAMBERLAIN, M. D.
President
S. C. Medical Association





HOUSE OF DELEGATES

ANNUAL MEETING — 100th SESSION

South Carolina Medical Association

Charleston, S. C.

Wednesday, May 12, 1948

2:00 P. M.

ORDER OF BUSINESS

- 1. Call to order—Dr. Olin B. Chamberlain, President
- 2. Report of Credentials Committee
- 3. Remarks by the President
- 4. Report of Director of Public Relations and Counsel-Mr. M. L. Meadors
- 5. Report of the Secretary-Dr. J. P. Price
- 6. Report of Council-Dr. Roderick MacDonald, Chairman
- 7. Appointment of Committee on Resolutions
- 8. Report of State Board of Health-Dr. W. R. Wallace, Chairman, Executive Committee
- 9. Report of Delegate to American Medical Association-Dr. Hugh Smith
- 10. Report of Rural Health Committee-Dr. Harold Gilmore, Chairman
- 11. Report of State Board of Medical Examiners-Dr. N. B. Heyward, Secretary
- 12. Report of the Cancer Control Commission-Dr. J. R. Young, Chairman
- 13. Report of Committee on Scientific Work-Dr. John Boone, Chairman
- 14. Report of Committee of Eighteen-Dr. Olin B. Chamberlain, Chairman
- 15. Report of Committee on Legislation and Public Policy-Dr. George D. Johnson, Chairman
- 16. Report of Committee on Medical Care for Veterans-Dr. Charles N. Wyatt, Chairman
- 17. Report of Committee on Public Health and Instruction-Dr. R. M. Pollitzer, Chairman
- 18. Report of Committee on Hospital Service-Dr. Robert Wilson, Jr., Chairman
- 19. Report of Committee on Medical Service-Dr. J. D. Guess, Chairman
- 20. Report of Committee on Industrial Health-Dr. Harry Wilson, Chairman
- 21. New Business

Election of Officers

President-Elect

Vice President

Secretary

Treasurer

Councilors

1st District (The term of Dr. J. W. Chapman expires this year.)

4th District (The term of Dr. J. B. Latimer expires this year.)

7th District (The term of Dr. C. R. F. Baker expires this year.)

Board of Medical Examiners

6th District (The term of Dr. E. M. Dibble expires this year.)

State at Large (The term of Dr. N. B. Heyward expires this year.)

Board of Examination and Registration of Nurses

One member (The term of Dr. L. Emmett Madden expires this year.)

Selection of place for 1949 Session.

The Journal of the South Carolina Medical Association

EDITOR: Julian P. Price		Florence, S. C.
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Please send in promptly notice of change of address, giving both old and new; always state whether the change is temporary or permanent. Original manuscripts, subject to approval by the Editor and the Editorial Board, are desired for publication in the Journal. They should be typewritten, double spaced, on $8\frac{1}{2} \times 11$ paper. References should be complete, and only such as relate directly to statements quoted in the paper. Illustrations will be used as funds permit, or as authors are willing to bear the necessary increase in cost. Short original articles are preferred to long reviews.

APRIL, 1948

ONE HUNDRED YEARS

One hundred years ago, eighty-eight of the leading physicians in South Carolina, representing seventeen districts, gathered in Charleston to consider the formation of a new organization. On February 16, 1848, a Constitution and By-Laws was adopted and the South Carolina Medical Association came into being.

As these men cast their vote one hundred years ago, what were the thoughts which coursed through their minds? Were they thinking in terms of months or years, decades or centuries? What changes did they imagine could take place in medicine and medical practice in the years to come?

What would these men think if they were suddenly brought back to Charleston today with its paved roads and automobiles, stream-liners and airplanes, radios and refrigerators, telephones and electric lights, moving pictures and television. What would they think of what they saw as they walked through Roper Hospital—the ophthalmoscope and the sphygmomanometer, the bacteriological laboratory and asceptic surgery, typhoid vaccine and diptheria antitoxin, the X-ray and electrocardiograph, aspirin and phenobarbital, insulin and vitamin compounds, the sulfonamides and penicillin.

What would they think of the thousand odd physicians who are now members of the organization which they started a century ago? Are these professional descendents of theirs leaders for the people of the state in affairs dealing with public and personal health? Are they skilled in the art as well as in the science of medicine? Does the love of fellowman rather than the love of mammon control their actions? Are they proud of their profession and of its tradition of service?

These questions will never be answered—but they are food for interesting speculation.

LEADERS

Once again, the time has come for us to choose those who shall lead us in the coming months. We do not possess the gift of prophecy, but the signs of the times point toward crucial days ahead. Clear thinking and aggressive action must be the keyword of our Association as we plan for the future. These thoughts should be appearment in our minds as we approach our annual elections at the coming meeting of the House of Delegates.

REPORT ON NATIONAL CONFERENCE ON RURAL HEALTH

The Third Annual meeting of the National Conference on Rural Health held at the Palmer House, Chicago, February 6 and 7, 1948, gathered together some 200 doctors and laymen from all parts of the nation. If one were in doubt as to the purpose of this Conference, he soon realized the general theme of the Conference to be that for better rural child health. It was based upon the National Health Program of the American Medical Association that: Every child should have proper attention, including scientific nutrition, immunization and other services included in infant welfare.

It was forcibly impressed upon us that the rural child was at a great disadvantage, as compared to the urban child, when it comes to medical care. Dr. Hubbard of Washington, Director, Child Health Studies, American Academy of Pediatrics, pointed out that one third of the population, comprising 13 million children, are in rural areas. They are served by 24% of hospital beds, 21% of the physicians and 19% of the dentists. The rural child has one half the average number of hospital beds and one half the average number of physicians. (The patient-physician ratio being one half that of national average). Obviously, then, the rural child doesn't get the best medical care this nation offers to the rest of the population.

Katherine Bain, of the U. S. Children's Bureau, states that the urban child gets four times more visits to the physician and more hospitalization than the rural child. Practically all pediatricians are in urban areas and the general practitioner sees 75% of all children. The urban child has benefit of periodic examinations, immunization injections, easy access to hospitals and specialists, in contrast to the rural child.

It used to be said that the country with its abundance of fresh air, sunshine, milk and fresh



JOSEPH I. WARING, M. D.

JOE WARING

Many members of the Association have worked diligently toward making our Centennial meeting a success, but there is one individual who deserves particular mention and thanks. That man is Joe Waring.

Two years ago Dr. Waring was appointed chairman of a committee to prepare a history of the Association. Working in and out of hours, he has assembled the data and has prepared the manuscript which is now in the hands of the printer. It will be ready for distribution to the members at the time of the meeting in Charleston. But that is not all. Dr. Waring was also appointed Chairman of the Committee on Arrangements and has had general supervision of making the plans for the meeting and of putting them into effect.

For what you have done and are doing, Joe, the members of the Association are truly appreciative.

vegetables was the healthiest place to bring up children but present day statistics show that the urban area is the healthiest place to live. Rural housing is at a low ebb. Food and clothing are problems in the rural areas moreso than in the urban areas. These three items are important in maintaining good health and cutting down the incidence of disease.

The most popular speaker on the program appeared to be Dr. Maurice Friedman of Washington, whose subject was: "Rural Youth and World War II." So enthusiastic was his address that he was called back after his time was up and allowed to speak a part of the discussion period. He stated that venereal disease, education and mental disease were the chief factors in the rejection of negroes in World War II. Educational defects were higher in rural than in urban areas. Contrary to popular opinion, however, rural acceptances were higher than urban acceptances (white and colored separated in statistics).

Parodoxically, many defects that caused rejections were due to good medical care—such as amputations, perforated ear drums and diabetes. Expert surgical and medical care had saved and prolonged lives of certain individuals which later were to be rejected for military service.

Mrs. J. L. Taylor of the National Cooperative Milk Producers Federation, made a plea for continuance of hot lunches in the schools throughout America. Schools having hot lunches showed better nutrition of children in that school. Furthermore, a survey revealed that the lunches that children bring to school are inadequate and unbalanced.

One of the highlights of the Conference was the panel discussion by four farm youths representing Producers Federation, Farmers Educational Cooperative Union of America, The National Grange and American Farm Bureau Federation. These young people voiced the sentiment of American youth for better rural medical care. It was enlightening to learn how well posted these young folk were on rural medical care. They know what they need and what they want and they are working along with others in the forefront of huge youth organizations over the country for better rural medical service. With such zeal and force they will push their ideas and aims before a large mass of the American people and whether they are right or wrong, they will, in time, bring about some form of medical care for the rural areas of the nation.

Just what can be done to bring about better rural health in general. Those things that bring about better child health? For all intents and purposes, better rural child health is better rural health in general. Those things that bring about better rural medical care will, also, bring about better rural child health and vice versa.

Any plan for better rural medical care must have two prerequisites: (1) More physicians must be graduated each year from our medical schools and (2) more of these physicians going into the rural areas. The big question is—how are we going to attract more physicians into the rural areas? South Carolina is making an effort on these two scores by enlarging her medical school and having a bill passed (now in the Legislature) to award scholarships to eligible men who will agree to practice in rural areas of S. C. the same number of years they hold their scholarships.

Certainly, the entire responsibility of getting physicians into the rural areas does not rest upon the shoulders of the medical profession alone. Each community needing and desiring a physician has a definite responsibility to meet in making that community attractive to a prospective physician.

That community should be progressive; work for good roads, good schools and cultural benefits; show a desire to support a physician by patronage and willingness and ability to pay for his services. If possible, to build a clinic or health center or hospital. It would take a physician with a strong missionary spirit to go into a community lacking good roads, schools and cultural advantages, to say nothing of the lack of medical facilities and indifference on the part of the population in supporting the doctor financially.

It is my humble opinion that the old fashioned "family doctor" days are passe, despite the fact that the A. M. A. is striving to give the general practitioner some recognition by presenting one with a medal each year and trying to get him recognized on hospital staffs. Time and economic conditions have brought about a permanent change.

I am convinced that one way to give better medical service in rural areas is by group practice. When I say group practice I don't necessarily mean five or six doctors with a couple of specialists in the group. I am thinking principally of two or three general practitioners-in most instances two-working together. In instances where more than two are together, one might lean toward one of the specialties. I am quite aware of the problems involved, such as congeniality of the group and financial arrangements. In this type of practice more and better service could be given the public. One would not be constantly tired out or tied down on the job. He would have time for vacations and post-graduate work. He would have the benefit of the help and knowledge of his colleague. The benefits of the Hill-Burton bill could be better utilized and kept closer to the practicing physician.

Another phase of better rural health is better housing and better food and clothing. In other words, better living conditions for the masses that really need it. It is the purpose of the Committee on Rural Health to set up health Councils in each county to work on a broad program for better rural health. What will be accomplished will take a long, long time. It is a problem that will require constant and strong effort on the part of many for many years to come.

In the words of Theodore Roosevelt—"Sickness is here, poverty is here, vice is around—but the happy thing is that someone cares and is trying to do something about it."

> H. S. Gilmore, M. D., Chairman Committee on Rural Health S. C. Medical Association

THANK YOU

Dr. Julian Price Secretary, South Carolina Medical Association Florence, South Carolina

Dear Julian,

I want to express to you, and through you to the South Carolina Medical Association, my great appreciation of your generous act in nominating me for the General Practitioner's Award of the American Medical Association. It made me feel very humble, but at the same time very happy, to be nominated by this group of men whom I esteem so highly. It was indeed most gracious of you, for we have many good men in South Carolina. I wish that I might have brought home the bacon to South Carolina. But even so, when the whole U. S. A. is involved, it's not bad for South Carolina to come out with second honors. Colorado's representative, Dr. Sudan, is a fine man and has done a grand job. In spite of his avoirdupois, when he got the ball he ran for a touchdown.

Thank you again for the many kindnesses shown me. I assure you, one and all, of my abiding appreciation. With kindest personal regards,

Yours most sincerely, W. L. Pressly

AMERICAN MEDICAL ASSOCIATION SAYS PUBLIC DEMAND FOR SERVICE AT NIGHT MUST BE MET

The American Medical Association calls on county medical societies to meet the public demand for emergency medical service at night.

"From many sections of the United States," says an editorial in a recent (March 6) issue of The Journal of The American Medical Association, "complaints have come lately that persons who have called physicians late at night have been unable to secure attendance from either those whom they considered their family physicians or from specialists or, indeed, from any physician."

The American Medical Association says that large county medical societies or urban groups should maintain a physicians' telephone exchange which would take the responsibility for locating physicians if response is not made to the ringing of the telephone in the home or in the office.

The solution is simple and practical, requiring only a minimum of community organization. A number of county medical societies already maintain a physicians' telephone exchange where doctors' calls may be received and doctors located if their office or home telephones do not respond. Such an exchange can be utilized as at night or on holidays, simply by furnishing the exchange with a list of physicians who are able and willing to make night calls. Such physicians would probably include the younger general practitioners, newcomers to the community, and others in general practice. If such a roster were available, and its availability widely publicized, night calls for medical service would soon gravitate to this center and the patient would be assured the services of a physician.

Under such a system the necessity for calling many doctors would be eliminated. Two calls at most would be necessary. Where there is no physicians' telephone service, it might be possible to have the hospitals cooperate by handling such night calls.

The Medical Society of the District of Columbia and the Milwaukee County Medical Society have found such a plan practical, as have a number of other societies.

By this simple and practical expedient, which is doubtless in effect in modified form in a number of communities, the siek can be served and the medical profession ean redeem its pledge of unselfish public service.

It is highly important that where such arrangements exist they be brought to the attention of the lay people in the community through appropriate public channels, not once but repeatedly, to keep the shifting populations well informed.

Few problems in the field of medical service have aroused so much public diseussion. Whether resentment against physicians is justified or not, it does harm. The solution for this problem is so eminently simple and would reflect so favorably upon physician-patient relationships that medical societies everywhere are urged to give it serious consideration immediately.

THE TEN POINT PROGRAM

THE HISTORICAL BACKGROUND AND THE OBJECTIVES OF THE SOCIALIZED MEDICINE PROGRAM

BY: J. DECHERD GUESS, M. D.

Americans are faddists. Fads are at first ideas of an individual or of a small group of individuals. The ideas spread and become fads by use of the principles of mob psychology, and the scope of any one of them depends more upon the enthusiasm, the tenacity, and the skill of the protagonists than it does upon the usefulness of the original idea.

Interest in health matters is now the fashion. It is a fad of widespread proportions and many different aspects. It has grown rapidly for the past three decades. Much of it is useful and some of it is life saving.

Siekness insurance is a subject of wide spread interest. This interest is being stimulated by several different groups. Commercial insurance eompanies are constantly trying to sell the idea and their policies. Voluntary, non-profit associations, like the Blue Cross and the Blue Shield groups have interested many people. It is said that one person in every three has some form and degree of siekness insurance. The most vocal advocates of siekness insurance are those seeking a universal eompulsory system under Government control. This is the form referred to as socialized medicine, state medicine, national health insurance, etc.

The idea of government controlled compulsory insurance is not new. There is at this time no great popular demand for it. However, its proponents would have you to believe otherwise. Such popular demand, as exists, has come about through the long time planning and scheming and working of a small group of individuals. Some members of the group are truly altruistic, some of them are primarily selfish, and some of them are fanatical dreamers. All are opportunists in that they see and seize upon circumstances or popular trends of interest, human misfortune, political expediency, and governmental opportunity to further their ideas and plans.

State medicine had its beginning under Bismark in Germany. It was poor man's medicine. Free medical care was given in exchange for the relinquishment of certain liberties. It was established in an effort to combat revolutionary tendencies of the poor, and to win their support for Bismark's system of State Socialism, or the autocratic state.

Margery Shearon in her, Blueprint for The Nationalization of Medicine, divides the evolution of the movement for state medieine in our country into three periods; The first, 1911-1925, when efforts were diffuse and without finished accomplishment. The second, 1926-1934, a period of organization. In this period several small groups, financed by philanthropic foundations, were organized and began to gather statistics on matters relating to the cost of medical care. In the third period, 1935-1947, the reformers have infiltrated the government and are in position to press their cause from within and to finance it with tax money to a greater and greater degree.

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Arthur J. Altmeyer, Assistant Administrator, Federal Security Agency and Commissioner of Social Security, became interested in compulsory sickness insurance plans in the first period. Isadore Sydney Falks, a long time student of methods of statistical study and of propaganda, the leader of the compulsory movement, the principal author of several versions of the W-M-D bills and now Director of the Bureau of Research and Statistics and the Chief of the Division of Health studies in the Social Security Board, with a salary of \$10,000 per year, began his steady rise in power and income before 1930. Altmeyer acts as a sounding board for the proposals of Falks, many of which are suggested by or come from the I. L. O., labor organizations in this country, social workers and others seeking social legislation.

Falk and Michael Merks Davis of the Rosenwald Fund unified the activities of various social reformers in the second period and then assumed the management of the program for the socialization of American medicine. By 1935 they had completed the organization, with slogans, statements of principles, and development of pressure groups. They were ready to start the propaganda program to which the public, the President, and the Congress has been subjected since that time.

Although they and many of their clique were in the government, either by executive appointment or through civil service, they disregarded or evaded laws against lobbying by governmental employees. They have requested and secured ever larger appropriations for their departments and divisions, and have spent large sums, more or less openly, for propaganda.

Let me quote several paragraphs from the third interim report of the Congressional committee on expenditures in the Executive Departments.

"Your committee concludes from the testimony that most, if not all of this literature (i. e. propaganda favoring socialized medicine) as distributed by the CIO, the AFL, the Farmers' Union, and the Physicians Forum originate in, and eminate from the Burcau of Research and Statistics in the Social Security Board

"Similar pamphlets were prepared in the same office for distribution as Government literature through the Department of Agriculture's Interbureau committee on Postwar Programs

"The same attitude of intolerance toward honest discussion or debate of the issue was indicated in the testimony of Mr. Harry J. Becker, health consultant in the U. S. Children's Bureau.

"We feel that devices and arrangements of Federal employees in this instance provide a typical example of how funds appropriated by Congress for the legitimate expense of Federal agencies are diverted within the bureaus to full time propaganda for what certain witnesses and authors of propaganda refer to as socialized medicine

"Certain documentary evidence also has come to the attention of your committee, that the Bureau of Research and Statistics in the Social Security Board also maintains contact with movements for compulsory health insurance in other countries......

"Suffice it at this time for your committee to report its firm conclusion, on the basis of the evidence at hand, that American Communism holds this program as a cardinal point in its objectives, and that in some instances known communists and fellow travelers within the Federal agencies are at work diligently with Federal funds in furtherance of the Moscow party line in this regard."

Senator Wagner has quoted from or referred to several publications in support of his bill. One of these is, "Principles of a Nationwide Health Program." There were 29 authors of this article. Seven of them were Federal officials who had a probable personal, financial and egotistical interest in the passage of the bill. Four of them were members of the National Citizen's Political Action Committee of CIO. One was a German born and educated doctor of medicine, who has for a long time been a writer and worker for socialized medicine.

Another publication referred to by the Senator is "Medical Care in A National Health Program." This is referred to as the American Public Health Association Platform. It was written by a subcommittee of 13, approved by a committee of 17, and adopted by the governing council of 49, but it has never been submitted to a vote of the 7,493 members of the Association.

That the W.M.D. bill is un-American is literally true. Its provisions and its existence eminated from the ILO. This organization was set up by the Treaty of Versailles of 1919, to improve social conditions throughout the world by the establishment of international standards for wages, hours, and working conditions. Its first director had been a leader of the French Socialist Party. Under his leadership ILO became an advocate of Socialism. All ILO member governments were pledged to strive to set up a system of compulsory social insurance, of which sickness insurance was a part. The U.S. joined the ILO in 1934, after Frances Perkins had brought in two ILO consultants to help draft the Social Security Act. The bill authorizing our union with this avowedly socialistic group was passed by legislative adroitness and trickery.

Falk and his subordinate Davis had been affiliated with ILO all along. John G. Winant, the first chairman of the Social Security Board, later became director of ILO. Altmyer, chairman of the S.S.B., was active in the creation, under ILO sponsorship, of the Inter-American Committee to promote Social Security in the entire American Hemisphere.

To recapitulate: The movement which has culminated in the introduction of bills proposed to

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Recently published, this booklet presents abstracts of the two authoritative reports which appeared in *The Journal of the American Medical Association*, November 8, 1947, showing the results of the use of Streptomycin in more than 900 cases of tuberculosis. It will be mailed to you on request.



establish a system of socialized compulsory Federal health insurance is the result of long standing effort of a comparatively small group of individuals. These people have succeeded in having their leaders intrenched within the government itself through executive appointment or through Civil Service. These leaders have disregarded laws against propaganda in the interest of legislation from government officials and employees. They have used money appropriated for the legitimate purposes of government to finance a vast program of propaganda in the form of studies and reports, lectures, meetings and experiments in the field of medical economics. They have included propaganda for National health insurance in books and pamphlets for wide distribution at government expense. They have succeeded by legislative adroitness in having the U.S. join the ILO, and in so doing the government is pledged to work for enactment of ILO programs. By reason of their governmental positions, they are able to exert pressure on legislation and to bring about the introduction of bills designed to further their objectives, to appear in hearings on these bills, and to secure the appearance of others of their cliques and to furnish them with arguments, and statistics and to brief them in the testimony they give.

Unfortunately, socialized medicine is not the ultimate goal of this group. Plans for socialization of medicine have progressed and are now plans for Nationalization. Our membership in ILO and our representation on the Permanent Inter-American Conference on Social Security has committed us to a national policy of comprehensive national social insurance of which compulsory sickness insurance is only a part. In 20 years, much has already been accomplished to bring this about. In all countries where Nationalism has succeeded, sickness insurance has been an early and important stepping stone. Great Britain is an example: First sickness insurance for the laborer, then nationalization of medicine, followed by government control of utilities, coal mines and banks. Next will come, if the process is not halted, nationalization of industry in general: shipping, land and finally government control and regulation of the people themselves-the socialized state, which sooner or later is indistinguishable from facism.

Quoting Loucks and Hoot in Comparative Economic Systems: "Every socialist program advocates a comprehensive scheme of social insurance "Without denying that systems of social insurance might be established and operated successfully under an economy essentially capitalistic in nature, the socialist argues that the efficient operation of a comprehensive scheme of social insurance is possible only under socialism Moreover, the socialist contends that the cost of protecting the individual against the uncertainties of income which lie outside his control should be borne by society as a whole, in the manner least costly to the group as a whole. To dis-

tribute the costs in this manner requires a fusing of incomes and accounts held to be impossible under a capitalistic economic system."

It is not at all beyond the realm of possibility, perhaps, even probability, that when the U. S. has adopted a comprehensive system of social security, because of the insistance that its operation would be less costly, more efficient, and more equitable under a socialistic government, efforts toward an actual change in our form of government may be made by the same groups now advocating socialized medicine.

The leaders draft the social insurance bills and pressure the Congress to pass them. These bills provide that the programs set up shall be administered by themselves. These schemes are a political and bureaucratic device to gain power over people and money, and they have little or no security for people as their objective.

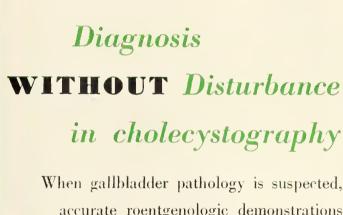
Only the Congress can stop this persistent, un-American, selfish, enslaving never discouraged and never ending movement.

Efforts have been made rather successfully to make it appear that there is a tremendous need and a popular clamor for compulsory sickness insurance. There is a need for more uniformly spread better medical care, and there is a clamor for sickness insurance. But the need for better care is not nearly so great as is claimed, and as false statistics and deductions from statistics make it appear. Nor is the clamor for costly sickness insurance so loud as is that for *free* insurance. But reports of popular polls do not always mention the difference.

In each Congress since 1943, there has been introduced one or more W.M.D. bills proposing a system of National health insurance, Each new bill is somewhat different from its predecessors, but, they all seek to set up a system of compulsory sickness insurance under government control.

There are now in Congress two important National health bills. One, S.545, is termed the Taft bill. This bill has been approved in principle by the AMA and other conservative groups and individuals. The other is S.1320 and is the latest edition of the W.M.D. bill. It has the backing of powerful reformers in and out of the government.

Some features of the W.M.D. bill are relatively non-controversial and in the main provide for the continuance of Federal aid in already established health programs. It is that portion of the act which would set up a nation-wide, bureaucratic controlled compulsory sickness insurance system which is new and is controversial, and which is the excuse for the bill. Its insurance coverage would be as wide as old age benefits under social security, and these latter will be broadened eventually to cover all employed persons. The sickness insurance would cover doctor bills, hospital bills, nursing and dental care, by doctors, hos-



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pitals, nurses and dentists under government contract. Free choice by the patient is theoretically allowed, but actually eould not apply. It would be limited by the fact that facilities and personnel chosen must be within the system and they must not already have accepted their quota under the regulations, and the patient must be acceptable to the doctor or hospital chosen by him. Further, if specialist's care is desired, it can be obtained only by reference by the general doctor, under restrictive regulations to be provided. If a patient prefers his own doctor, at his own expense, he still must pay premiums in the form of payroll deduction or by general taxation to support the insurance plan.

Doctors do not work entirely for money, or for popularity, or for fame, or for the satisfaction of professional success. They work for all of these and where they are lacking, as they would be in practice under government contract, doctors will not work so well nor so diligently, and the quality of medical care of the nation will deteriorate. Thus, the loudly proclaimed chief objectives of the bill, false though they be, will fail of accomplishment. The people will not have better medical care. They will not have choice of attendant. They will not pay less for more care. The health of the nation, will not be improved, and those mental and emotional deficiencies and those physical deformities which figured so prominently in draft rejections, and which are included in statistics offered to prove the need for better medicine, will not be prevented. There is no reliable estimate of the cost of the scheme now or later. There is included in the present bill no method of financing it. Presumably part would be paid by payroll deduction or percentage contributions based on income. Deficiencies would have to be met from the general treasury funds.

The Taft bill is not an insurance bill. It seeks by grants-in-aid to the states, which states shall also appropriate equal funds, to provide medical and hospital care to the medically indigent. The state will make its own program and will manage it very much as it does its cancer control, crippled children and maternal care programs. There is specific anthorization in the bill, if a state wishes to do so, to use the facilities of voluntary non-profit associations like Blue Cross and Blue Shield. Funds may be used to increase the income of physicians whose location cannot adequately support him.

The reformers are fighting the Taft bill on the grounds that it requires a paupers oath to qualify for its benefits, that it does not go far enough and that it will be dominated by the medical profession.

It is my opinion that the W.M.D. bill cannot pass this Congress, if for no other reason, than because of its costliness. The Taft bill, with some alterations, does have a fair chance of a favorable committee report, and if it gets that, then a fair chance of enactment. A veto might kill it if it is passed, for the President has advocated a compulsory universal insurance plan.

Whether the Taft bill passes or not, South Carolina must make provision for its indigent and its low income groups. Free medical eare, a contribution of the medical profession, and hospitalization when truly necessary, at public expense takes care of the indigent with varied completeness. The Blue Cross plan of prepaid hospital care is increasing its enrollment satisfactorily, but is hampered because so many groups desire combined hospital and surgical or even general medical coverage. Private companies offer that type of contract, but at a profit. We must have Blue Shield as well as Blue Cross. An enabling Act passed the House last winter, but is still held in committee in the Senate. Our hands are tied until this or similar legislation is passed. Some insurance companies are fighting it. When enabling legislation is enacted the state medical association will attempt to set in operation a medical service plan which will affiliate with Blue Cross, and will offer non-profit prepaid medical eare to our people with low or moderate incomes.

Con't. on p. 152

NEWS ITEMS

Dr. Edward Fincher of Atlanta was the guest speaker at the February meeting of the Spartanburg County Medical Society. His subject was "Some Neurosurgical Attempts to Relieve Pain."

The Board of Examiners of the American College of Chest Physicians announces that the next oral and written examinations for Fellowship will be held at Chicago, June 17, 1948. Candidates for Fellowship in the College, who would like to take the examinations, should contact the Executive Secretary, American College of Chest Physicians, 500 North Dearborn Street, Chicago 10, Illinois.

At the February meeting of the Chester County Medical Society, Dr. Furman Wallace and Dr. Euta Colvin of Spartanburg addressed the Society on the subject "Total and Partial Gastrectomy." They presented lantern slides on a series of five cases.

The Annual conference of the American Physiotherapy Association will be held at the LaSalle Hotel, Chicago, May 23-28, 1948.

Dr. J. F. Highsmith, Jr., formerly of Fayetteville, N. C., has announced the opening of Proctology and Varicose Vein Clinic at Myrtle Beach.

Johnson-Allen

Mr. and Mrs. Robert Neill Johnson of Marion have announced the engagement of their daughter, Lucta, to Dr. James Allen of Florence.

Speed-Watkins

Mrs. Howard Owens Speed of Columbia has announced the engagement of her daughter, Althea Owens Speed, and Dr. Robert S. Watkins of Columbia and Charlotte.

We extend to Dr. W. M. Powe, Sr. of Greenville, our deepest sympathies in the recent death of his mother at Hartsville.



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- 1 Arbesman, C. E. et al. Jl. of Allergy 17:275, Sept. 1946.
- 2 Fuchs, A. M. et al. Jl. of Allergy 18:385, Nov. 1947.
- 3 Feinberg, S. M. and Friedlaender, S. Am. J. Med. Sci. 213:58, Jan. 1947.

ISSUED: Scored tablets 50 mg. • Elixir, 5 mg. per cc.

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ABSTRACTS

Paxton, J. R. and Payne, J. H.: Acute Pancreatitis, Surg., Gynec., & Obst. 86: 69-75, Jan. 1948

An analysis of 307 patients with established diagnosis of acute pancreatitis from January 1933 to January 1946 was presented.

The disease was usually found in patients in the third decade of life, more common in women than men, and more prevalent in warm weather. Initial pain immediately following ingestion of a heavy meal in 25% of the cases was called "gastritis, indigestion, or dyspepsia." Fifty-five patients were intoxicated or recovering from a recent alcoholic bout. Pain, nausea. and vomiting were predominating symptoms. Epigastric pain, with radiation to back, was sometimes found. However, the pain was sometimes generalized abdominal; right upper quadrant radiating to the back; or even in the lower abdomen extending to one or both flanks. Flank pain and tenderness were of definite diagnostic significance. Reflex vomiting appeared early, was generally persistent. Later vomiting depended on the amount of ileus or duodenal obstruction.

Clinically, the disease usually fell into 5 groups: (1) acute abdominal distress, shock, hyperpyrexia, and death in 24 hours, with coronary occlusion often erroneously suspected. (2) simulated acute cholecystitis, (3) imitated mechanical small intestinal obstruction without obvious cause, (4) resembled alcoholic gastritis, (5) a mass in the epigastrium or left upper quadrant following acute pancreatitis 3 or 4 weeks previously.

Gastro-intestinal hemorrhage occurred in 24 patients. Diarrhea was noted, but less common than constipation. Clinical hypertension was found in 20% and 78% showed no evidences of shock.

Laboratory aids in diagnosis were: (1) elevated blood amylase about 12 hours after onset of symptoms, (2) elevated urinary diastase 24 to 36 hours after onset, (3) depressed blood calcium, (4) x-ray evidences of segmented ileus, (5) electrocardiagraphic changes, (6) elevated blood sugar and sugar in the urinc. The above examinations varied with individual cases. The first two of these were considered most important.

Treatment was aimed at placing the pancreas at rest by continuous gastro-intestinal suction, adequate parenteral fluids, regular use of morphine sulfate, and regular large doses of atropine sulfate. Relief from pain could be obtained by paravertebral sympathectic blocks (T4-9). X-ray therapy sometimes altered the course favorably. Intensive conservative treatment

was continued until the temperature had been normal for a minimum of 48 hours.

The over-all mortality was 33,3%. The mortality rate of patients operated upon was 44.7%, compared to 21.3% in the group not operated upon. An operative procedure designed to prevent recurrences was to section the vagus nerves, thereby preventing stimuli to the pancreas from the stomach.

Thiouracil and Allied Drugs in Hyperthyroidism E. C. Bartel: New Eng. J. Med. 238: 6-11 January 1, 1948

The new antithyroid drugs, which include thiouracil, thiobarbital and propylthiouracil, if properly administered will lower the basal metabolic rate of all patients with primary hyperthyroidism or adenomatous goiter with hyperthyroidism. All signs and symptoms of hyperthyroidism except prominence of the eyes subside with treatment.

The production of thyroxin is halted when these drugs are given in adequate dosage. This is shown by a reduction in the blood protein-bound iodine and in the iodine content of the thyroid gland. No histologic change in the thyroid tissue occurs with these drugs. Hyperplasia of the gland may even increase. It must be recognized that the histopathologic change originally bringing about the hyperthyroidism is still present even after the basal metabolic rate has been restored to normal.

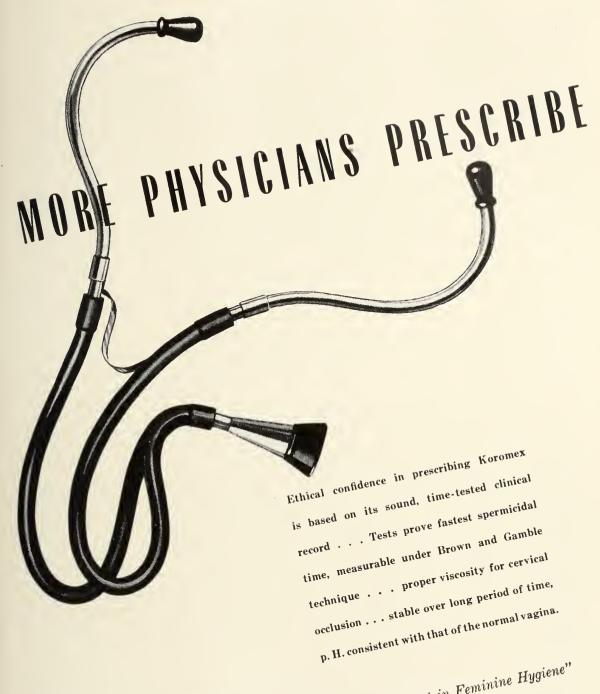
Experimental work indicates that these substances act by preventing the synthesis of iodide to an active protein-bound hormone. They probably inhibit the peroxidase or enzymatic system in the thyroid that brings this synthesis about.

The comparative daily effective dose of thiouracil and propylthiouracil are 600 mg. and 200 mg. respectively. These dosages may have to be adjusted to the individual patient. The author now uses propylthiouracil exclusively.

Reactions to thiouracil consist of depression of white count, fever, swollen salivary glands, skin rash and edema of the skin. Dr. Bartels has seen 1 fatal case of agranulocytosis.

Thiobarbital (28%) shows the highest incidence of complications. Thiouracil shows a moderate incidence (9%) and propylthiouracil (1.6%) by far the lowest. Propylthiouracil is not entirely unattended by significant side effects however and the author has seen 1 case of agranulocytosis following its use.

Prolonged remission occurs in some patients with mild hyperthyroides in whom the thyroid is enlarged slightly. Apparently the duration of treatment has little to do with the duration of remission so long as



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the basal metabolic rate is normal when the drug is withdrawn.

Relapse in two to six months occurs after the reduction of dose or withdrawal of antithyroid therapy in patients with a high degree of hyperthyroidism and substantial thyroid enlargement.

Maintenance therapy with antithyroid drugs is possible but it entails periodic observations which must include blood studies, metabolic studies and further adjustment of the dose.

Other serious objections to maintenance therapy include such factors as: failure to bring about cure of the hyperthyroidism; persistance of goiter; inherent dangers in not removing adenomatous goiters; possible reactions to medication and possible development of serious histopathological changes in the thyroid gland.

It is the practice at the Labey Clinic to give patients both propylthiouracil and Lugol's solution simultaneously from the beginning of treatment. The iodine aids in early clinical improvement as well as reduces the vascularity of the gland in preparation for thyroidectomy. Patients with adenomatous goiter do not require iodine.

As preoperative adjuncts to thyroidectomy these new drugs have filled a great need and if properly used permit the elimination of operative reactions and mortality.

Mvocarditis

Ira Gore, Otto Saphir: Am. Heart J. 34: 827-831 December, 1947

The authors review 1, 402 cases of myocarditis verified by pathological examination.

During the early part of this century the clinical diagnosis "myocarditis" fell into disrepute following a period in which it has been used indiscriminately to designate any cardiac disorder not accompanied by an organic murmur. This led to many instances of misdiagnosis in cases of hypertensive and arteriosclerotic heart disease. However, further perpetuation of the idea that myocarditis for all practical purposes does not exist; is a clinical hazard; correct diagnosis was rarely made in any of this large number of cases.

Diagnostic failure cannot be attributed to an absence of signs or symptoms. Clinical records frequently mention cyanosis, dyspnea and orthopnea. A significant degree of hypotension was often observed and with it a weak, feeble, or thready pulse. Often the recorded pulse rate and temperature showed a loss of the normal ratio. Sometimes chest pain, characterized by substernal oppression or discomfort was observed. Electrocardiograms, in the majority of cases in which they were taken, disclosed evidence of myocardial damage. Manifestations of congestive heart failure which occurred in an appreciable number of cases, included distended neck veins, serous effusions, swollen tender liver and dependent edema. Unexpected deaths were numerous and in the small number of patients surviving for periods ranging from 1 to 6 months, embolic phenomena were observed.

Clinical recognition of myocarditis in scrub typhus became more frequent as physicians became more aware of the incidence of carditis in fatal cases,

Known etiological agents in myocarditis include: toxic substances (diphtheria); physical or chemical agents (heat stroke and carbon monoxide poisoning); various specific virus, rechettsial, spirochetal and fungus diseases; less specific infectious processes and various metabolic states such as inanition and hypersensitivity.

Myocarditis was not encountered among 80 cases of typhoid fever nor in 30 cases of bacillary dysentery.

Although some of the myocarditides seem to be of academic rather than of clinical interest it is axiomatic that sound therapy can be based only on accurate appraisal of pathological alterations. Myocarditis occurring with septicemia and subacute bacterial endocarditis was an academic problem before the adoption of sulfonamide and penecillin. It is known to be responsible for many of the fatalities in the "bacteriologically cured" or arrested case of these diseases treated with the newer therapeutic agents.

The Management of Hypertension Paul D. White: Ann. Int. Med. 27: 740-749

November, 1947

The present day concepts of treatment of hypertension are reviewed. The known causes of high blood pressure and serious complications such as heart disease, apoplexy and renal insufficiency are not dealt with.

The education of the patient is the most important consideration at the start. While there is a difference of opinion about this, Dr. White keeps his patients, in most instances, informed about the general status of their blood pressure.

The patient is advised as to a proper way of life. This varies from slight restrictions in the border line case to complete rest for extreme hypertension with threatened cardiovascular or renal failure. Leisure is prescribed in so far as possible. Hours of work and intensity of work are reduced.

The pleasure and relaxation to be obtained at the various mineral springs may have some value. The unhurried mild exercise as well as the physiotherapy to be obtained at these baths are of value.

Sleep itself is very important. If sleep evades the patient a hypnotic medicine will usually help. Nine or ten hours in bed every night and an hours rest in the middle of the day should be prescribed.

Dr. White advises his hypertensive patient to give up smoking entirely even though in the rare case, there seems to be little or no effect.

Coffee and tea seem to have no harmful effects. Alcoholic drinks may have a favorable and sedative effect but they should not be taken in excess nor to the extent that they produce an increase in weight.

Psychotherapy is considered at some length with

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reference to the writings of Binger (Binger, Carl: A critique of psychotherapy in arterial hypertension, Bull. N. Y. Acad. Med. 21: 610, 1945). This author's statement that "There is as yet no evidence that psychoanalysis or any other psychotherapeutic procedure can reverse the physiological process or change the destiny of the disease"—is quoted in context along with his reminder that almost all therapy in hypertension is in essence psychotherapy.

The revival in the interest in dietary treatment is reviewed. The author comments on the rice diet of Kempner at the Duke clinic.

This low protein, low sodium diet is reported to help about two thirds of those hypertensive patients who are willing to give it a fair trial. Those obviously unfitted for surgery might try it. It seems reasonable to suggest to try this diet first and if it is unsuccessful it is still possible to operate.

Drug therapy includes the sedatives and the nitrites. The smaller doses of barbiturates throughout the day help some. Opiates except in crises should be avoided. The nitrites lower the pressure but as a rule too transiently to be of benefit. Mannitol hexanitrate which acts more slowly is becoming more widely used.

Potassium thiocyanate lowers the blood pressure in some cases. It is often disappointing and can be quite toxic. Blood levels should be occasionally checked. A number of other drugs are named none of which has been widely or permanently adopted.

The newest drugs being tried in hypertension today are the tetra ethyl ammonium salts and priscol. These chemicals more or less paralyze the sympathetic nervous system and it is to be hoped that one will be found that will bring the blood pressure down for a long period without disturbing side actions. Their use must still be considered in the experimental stage.

The surgical treatment par excellence is sympathectomy. The more extensive lumbodorsal sympathectomy of Smithwick has been worthwhile in two-thirds to three-fourths of those operated on. It has been life saving in a number of the author's patients who had already developed hypertensive heart disease.

Until some specific means of treating hypertension is discovered we should avail ourselves of all the measures that have proved worthwhile in the management of the early hypertensive as well as in those serious cases whose days are otherwise numbered. Pulaski, E. J., Seeley, S. F., & Matthews, C. S.: Streptomycin in Surgical Infections—Peritonitis; Surg.: 22, 889-999, December, 1947

The progressive decline in the mortality in peritonitis of various origins was credited to chemotherapy, antibiotic therapy, constant intestinal decompression, anticipation and correction of protein depletion, correction of fluid and electrolyte balance, and measures to prevent as well as to treat thrombophlebitis and phlebothrombosis.

Following rupture of the hollow viscera in adults *Escherichia coli*, aerobic and anaerobic nonhemolytic streptococci, and Clostridia have been usual causes of peritonitis; whereas, in very young children the cocci groups predominated. These organisms had varying susceptibility to streptomycin, penicillin, and the sulfonamides.

Sixty-three cases of peritonitis of various etiologies, largely in healthy young males, were reported. There were 5 deaths, 3 from non-bacterial causes and the other two from generalized fibrinopurulent peritonitis.

Streptomycin was found effective in early spreading peritonitis, whether used alone or with penicillin. Resolution of established peritoneal suppuration followed nearly the same pattern when either streptomycin or penicillin was used. The effects of streptomycin on localized peritonitis were limited but enhanced by the use of penicillin.

Streptomycin dosage varied from 1 to 4 gms. daily given intramuscularly at 3 or 4 hour intervals. Penicillin between 120,000 and 600,000 U. per day. The average sulfadiazine dose was 6 gms. daily. Patients receiving 3 gms. daily of streptomycin alone, or 2.5 gms. combined with about 480,000 U. penicillin, had the most satisfactory postoperative convalescence. Inadequate doses (1.5 gms. daily or less) of streptomycin usually resulted in indifferent responses.

On the basis of these studies it was apparent that streptomycin was not a panacea, yet had a valuable place in the treatment of peritonitis. Used in combination with penicillin, it was effective in many patients who failed to respond to penicillin alone or penicillin combined with the sulfonamides.



DEATHS

THEODORE MADDOX

Dr. Theodore Maddox, prominent physician and surgeon of Union, died on March 12 in an Asheville, N. C. hospital.

Dr. Maddox was born in Clark County, Georgia, in 1873. He received his education in the public University Medical School (Class of 1902). Immediately upon his graduation, he began the practice of medicine in Union where he practiced until his death except for the years 1916-1919 when he served in the

Surviving Dr. Maddox are his widow, the former Miss Mary Leonard Murphy of Charleston, two sons

and one daughter.

MANNING L. NELSON

Dr. Manning L. Nelson died February 21 at the Baptist Hospital in Columbia, after suffering a heart attack several days earlier. A native of Charleston, Dr. Nelson attended the public schools in that city, was graduated from Belmont College in North Carolina and the Medical College of the State of South Carolina (1909). In 1910 he married Miss Leila Boles of North where he lived until his death.

Dr. Nelson was a member of the Edisto Medical Society, the South Carolina Medical Association and

the American Medical Association.

ARTHUR H. BROWN

Dr. Arthur H. Brown of Oswego died on March 6 at a hospital in Sumter after a long illness.

Dr. Brown was born in Camden, October 17, 1872. He was graduated from the Medical College of the State of South Carolina in 1900 and had practiced medicine in Oswego for 45 years.

Survivors include his widow and one adopted son.

DOCTOR FURMAN THOMAS SIMPSON

The call to higher service came to Doctor Furman Thomas Simpson on the morning of January 29th, 1948, as he was preparing to go about his accustomed ministry to the sick and needy. Though friends had known for some time that Doctor Simpson was working at a sacrifice of strength, they were so aware of his loyalty to duty that it was almost incredible that he had slipped away so suddenly.

Doctor Simpson was born and reared in Oconce County, where his name will ever be held in tenderest memory: as a distinguished member of the Medical Profession, as a faithful christian, as a loyal friend, and as a devoted husband and father.

Whereas in the providence of almighty God, our Heavenly Father, it has been His will to remove from our midst our beloved friend and brother in the profession, Doctor Furman Thomas Simpson, and to call him from his labors among us to eternal rest; and

Whereas, in his going we are conscious of our loss; to ourselves of one who had proved himself a tried and true friend; to our church of a wise and consecrated leader; to our community and city of a citizen who took an active part in every civic, moral, and religious movement; and to the Medical Profession of one who, with consecrated skill, ministered to the sick and needy:

Therefore, be it resolved by the Oconee County Medical Society:

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PHOSPHORUS		VITAMIN D		
IRON	12.0 mg.	COPPER	 	0.50 mg.

*Based on overage reported values for milk.

Ist, That we bow in humble submission to the will of God in His taking to Himself His faithful servant;

2nd. That we hereby express our sincere appreciation for his life and service in the Medical Profession;

3rd. That we express our deepest sympathy to the members of his family in the bereavement which they have sustained:

4th. That a copy of these resolutions be spread on the minutes of the Oconee County Medical Society, and that a copy be sent to his wife and children, and a copy be sent to our State Medical Association.

Respectfully,

Wm. A. Strickland, M. D. For the Committee

WOMAN'S AUXILIARY SOUTH CAROLINA MEDICAL ASSOCIATION

President: Mrs. D. F. Adcock, Columbia, S. C.

Publicity Secretary: Mrs. Kirby D. Shealy, Columbia, S. C

YORK COUNTY MEDICAL AUXILIARY

Mrs. D. F. Adcock of Columbia, president of the South Carolina Medical Auxiliary, was guest speaker at a luncheon meeting of the York County Medical Auxiliary.

Mrs. Adcock spoke of the aims and accomplishments of the organizations during her term of office. She said that increased membership was one of the main objectives of the organization.

Mrs. K. D. Shealy, also of Columbia, state publicity secretary of the organization, was a special guest.

During the business session Mrs. W. D. Williams reported on the county organization's efforts to secure nurse recruits and said that splendid co-operation has been secured from all school principals.

Mrs. J. L. Bundy told of plans being made for the

Doctor's Day dinner in March,

A nominating committee was named to make a report at the March meeting. Mcsdames Gaston Quantz, Angus Hinson and Frank Gaston were named to this group.

Eighteen members of the auxiliary were present for

the luncheon.

WOMAN'S AUXILIARY TO THE COLUMBIA MEDICAL SOCIETY

The Woman's Auxiliary to the Columbia Medical Society convened at the Hotel Columbia for a luncheon meeting at which Mrs. David S. Adcock was the guest speaker. Mrs. Adcock gave an interesting and informative account of the founding and growth of Medical Auxiliaries in the South and other parts of the country. "In South Carolina," she said, "the membership has grown from 216 to 405 in the past two years." She stressed the importance of the Nurse Recruitment program sponsored by all the auxiliaries and said there had been a definite increase in the enrollment of student nurses within the past year.

During the business meeting of the Auxiliary, officers for 1948-49 were elected. Mrs. Kirby D. Shealy, former president-elect will serve as president, assisted by Mrs. William Weston, Jr., president-elect, Mrs. Walter Bristow, viee-president, Mrs. Gordon Seastrunk, secretary, and Mrs. Henry Plowden,

treasurer.

Mrs. W. P. Beckman, chairman of the Nurse Recruitment program, presented the awards to Miss Jerry Spigner and to Miss Beverly Wingate, winners of the essay contest on "Why I Should Like To Be A Nurse," Mrs. George Bunch presented a revised constitution which was voted upon and accepted by the auxiliary. Mrs. James G. Shaw explained the housing survey which will be sponsored by the Council for Social Planning and asked that members of the auxiliary volunteer their services.

Members of the auxiliary were invited to attend the South Carolina State convention of the Medical Auxiliary which will be held in Charleston, May 12, 13, and 14. The following delegates were elected, Mrs. Kirby D. Shealy, Mrs. William Weston, Jr., Mrs. Walter Bristow, Mrs. Gordon Seastrunk, Mrs. Henry Plowden, Mrs. R. G. Latimer, and Mrs. R. Wilson Ball,

Alternate delegates are Mrs. Thomas D. Dotterer, Mrs. Leland Brannon, Mrs. Harold Miller, Mrs. Harry Wilson, Mrs. C. J. Milling and Mrs. Grady Waddell.

THIRD DISTRICT AUXILIARY

The Woman's Auxiliary to the Third District of the South Carolina Medical Association held its regular luncheon meeting at the Oregon Hotel in Greenwood, March 2 with twenty-one members present. Mrs. M. J. Boggs, president, presided over the meeting.

Miss Virginia Philips and Mrs. Charles Fuller of the Greenwood County Health Department were guests of the Auxiliary at this meeting through the arrangements of Mrs. H. B. Morgan, Ware Shoals, chairman of the program committee. They presented the program of the Health Department for Crippled Children. A movie was shown which illustrated various cases of the program and the benefits achieved from physical therapy in treatment of infantile paralysis.

The following new officers for the coming year were elected:

Mrs. W. G. Bishop, Greenwood, president Mrs. J. C. Scurry, Greenwood, vice-president Mrs. F. C. McLane, Ware Shoals, secretary Mrs. T. I. Stanfield, Abbeville, treasurer

PICKENS COUNTY AUXILIARY MEETS

The Pickens County Medical Auxiliary met in Pickens, February 12 at the home of Mrs. J. L. Valley, with Mrs. N. C. Brackett, assistant hotsess, Mrs. C. E. Ballard, president, called the meeting to order and welcomed as a new member, Mrs. Clive Higgins, mother of Dr. Clive F. Higgins, Mrs. W. B. Furman led the devotional, using the 124th Psalm, a short talk, and prayer. Reports of officers and minutes were heard and approved. At this meeting election of officers for the coming year was held. Those elected were:

President—Mrs. Gaines Cannon Vice-president—Mrs. C. E. Ballard Secretary—Mrs. T. P. Valley Treasnrer—Mrs. T. R. Gaston Historian—Mrs. Nettie Jameson

For the program, Mrs. Jameson read the history of Dr. Lawrence Garvin Clayton, 1854-1935. The Woman's Creed concluded the meeting after which the hostess served a salad course with coffee during the social hour.

TENTATIVE PROGRAM

WOMAN'S AUXILIARY TO THE SOUTH CAROLINA MEDICAL ASSOCIATION

Meeting Headquarters: Fort Sumter Hotel

Charleston, South Carolina

May 12th 13th and 14th

11:00 A. M. Auxiliary committee meets with Council of Medical Society

Mezzanine Room, Francis Marion Hotel

4:30 P. M. Student Loan Fund Committee Meeting

Fort Sumter Hotel-Mrs. T. A. Pitts, Chr., presiding Mrs. Vance W. Brabham, Sr., Co-chr.

5:00 P. M. Executive Board Meeting

Fort Sumter Hotel-Mrs, David F. Adcock, presiding

6:30 P. M. Executive Board Dinner-Dutch

Fort Sumter Hotel

THURSDAY, MAY 13th

Registration continued

Francis Marion Hotel and Fort Sumter Hotel

9:30 A. M.

House of Delegates Fort Sumter Hotel-Mrs. David F. Adcock, presiding

11:00 A.M.

Program Meeting

Fort Sumter Hotel-Mrs. David F. Adcock, presiding Invocation

Address of welcome_____Mrs. J. A. Siegling, Charleston Response _____Mrs. M. E. Hutchinson, Columbia

Honor Guests _____Mrs. Eustage A. Allen, President

Woman's Auxiliary to the American Medical Association

Atlanta, Georgia

Mrs. Olin S. Cofer, President

Woman's Auxiliary to the Southern Medical Association

Atlanta, Georgia

1:00 P. M.

Auxiliary Luncheon-Dutch

Yacht Club

Guest Speaker _____Dr. Walton Van Winkle, Jr.

Secretary Therapeutic Trials Committee of the Division of Therapy and Research

American Medical Association, Chicago, Illinois

Subject: "New Research Discoveries" Post Convention Executive Board Meeting

Fort Sumter Hotel-Mrs. P. M. Temples, presiding

Thursday afternoon: Planned entertainment by Charleston Auxiliary

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Con't. from p. 142

PREPAYMENT MEDICAL CARE PLAN NOW POSSIBLE

The Bill to provide for the incorporation of nonprofit prepayment medical care plans in South Carolina, authorized by the Association and approved by the Committee, of which Dr. J. D. Guess of Greenville is Chairman, was adopted and became effective as Act No. 892 on March 31, 1948.

It will be recalled that the Bill passed the three readings necessary in the House of Representatives last year, and in the Senate was referred to the Committee on Medical Affairs which took no action during that session. This year the Committee considered the Bill and gave it a favorable report whereupon it passed the two remaining necessary readings without amendment and was subsequently signed by the Governor.

The Act provides for the organization of non-profit plans under the sponsorship of the doctors for prepayment for medical services at rates that will be within the reach of the lower income group. It is similar to the Blue Cross Hospital Service Plan but coverage will be on an indemnity rather than a service basis. It is entirely in line with the recommendations of the American Medical Association and with plans already in effect in most of the other states. The Act, of course, sets up no organization, it simply provides the authority. The formation of the plan is up to the doctors. This is a matter which deserves immediate careful consideration, and one which is entirely in line with the public relations program now in effect.

Further treatment will be given the subject in a future issue of the Journal. It is one that should be thoroughly understood by all members of the Association for their cooperation is essential to its success.

First of all, of course, there must be a decision to organize such a plan and preceding that, further study of the ways and means by the present or some other committee would be in order.

OTHER LEGISLATIVE ACTION

As of April 1st, it appears very doubtful whether after all there will be any change in the organization of the State Board of Health this year. The much discussed Bill for the reorganization of the Health Department was introduced in a form generally acceptable to the Medical Association, after considerable attention had been given to it by the Senate Committee on Medical Affairs. It received its first reading in the Senate on March 11th and the second on March 18th. As the session draws to a close, other matters which are contested and have priority remain to be considered in the Senate and, since there seems to be no especial disposition on the part of anyone to take the Bill up out of order, it appears entirely possible that it may not be reached for consideration. Events in the Legislature, however, are always uncertain and if the session should be extended longer than now seems probable, the Bill may become law before this is read.

The effort to obtain an investigation of the Board of Naturopathic Examiners was bitterly contested by the Naturopaths and their friends. A Resolution identical with that which passed both Houses last year but then disappeared, was introduced in the House of Representatives and passed in March 1948. On reaching the Senate it was immediately referred to the Senate Committee on Medical Affairs and a Hearing was requested on behalf of the Naturopaths. After some little delay the Hearing was set for Wednesday afternoon, March 24th. Unfortunately, and despite efforts to have the Medical Association well represented, only three doctors were present. The Naturopaths were there in force together with their legal counsel, Mr. N. A. Theodore of Columbia. The Resolution was attacked by its opponents as being unfair and the instrument of a "smear eampaign." It is known that certain members of the Senate Committee on Medical Affairs are friendly to the Naturopaths and, of course, no member of the Legislature should be criticized for insistence upon fair and impartial treatment for every citizen and group of citizens in the State. There is certainly, however, no unfairness in the Resolution and it is hard to see what basis there can be for opposing a move to investigate and find out the real truth of a situation regarding which there has been already in the press and elsewhere so much indication that all is not as it should

Following the Hearing on March 24th, action was deferred to allow the Committee an opportunity to hear from the Chief Law Enforcement Officer, who cooperated in 1947 with representatives of the Connecticut State Department of Police in making an investigation of a number of Naturopaths who had applied for license there on the basis of the reciprocity arrangement existing between the two States. A meeting of the Committee to hear a representative of the Law Enforcement Division was scheduled for Tuesday, April 6th, and we hope that by the time this is read, the Resolution will have been favorably reported by the Committee and approved by the Senate. If that is the case and the investigating committee is empowered to proceed, there should be a report ready to be submitted to the 1949 session of the General Assembly which will indicate what further action, if any, the lawmakers should take with respect to this particular group.

OUR ADVERTISERS

We wish to call to the attention of our readers the names of those firms which have contracts with us for advertising during 1948:

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Parke, Davis & Company

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Brook Haven Manor Sanitarium Rhem's Drug Company

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X-Rays in the Treatment of Common Inflammatory Conditions

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INTRODUCTION:

This article is being written to acquaint and reacquaint physicians with the benefits that superficial and deep x-ray treatments offer in certain inflammatory conditions.

Prior to the days of the chemo-therapeutic agents and antibiotics, x-ray treatment was used considerably in the treatment of inflammatory conditions and much more so than at the present time. Due to the inefficacy of most forms of treatment in inflammatory conditions prior to the newer modalities, x-ray treatment was used in many conditions and in various ways. In some of these conditions no beneficial effects were obtained and in many instances the treatment was improperly applied so that untoward effects (severe x-ray reactions and late x-ray skin changes) were experienced.

Because of the increased use of sulfa drugs, the antibiotics and because of the bad reputation that x-ray therapy got as the result of its improper use, it fell into disuse in the treatment of inflammatory conditions. We now know that it can be of considerable use in controlling certain acute and chronic inflammatory conditions including those which respond to the chemo-therapeutic and antibiotic modalities.

In our present article we intend to mention only the more common inflammatory reactions in which x-ray therapy may be of particular benefit. Our report will be based upon our personal experience and anyone desiring a complete analysis of the treatment of inflammatory lesions and a review of the literature we would like to refer to the article written by E. P. Pendergrass, M. D. and Philip J. Hodes, M. D.1

RATIONALE OF X-RAY TREATMENT IN INFLAMMATION:

In the acute inflammatory process such as a carbuncle or furuncle it is well known that x-ray treatment given early in the course of the lesion will abort it and, when given later, will cause it to suppurate earlier than without x-ray treatment. When

one considers the pathology of such inflammatory lesions with the leukocytic infiltration, the sealing off of the inflammed area by lymphatic and vascular thrombi and the cell destruction in the midst of the inflammatory process, it seems reasonable to assume that radiation therapy by producing an increase in the blood supply, may, by increasing the amount of blood and lymph flowing to the infected region, increase the amount of antibody reaction in the infected area and thus bring about a resolution of the infection quicker than if the inflammatory region were to remain sealed off.

It is known that x-rays are bactericidal, but it is also recognized that they are only bactericidal in huge doses, more than are ever used in human therapy. It is also known that x-rays have an effect on the bactericidal ability of blood and the exact mechanism by which blood is made more bactericidal by the x-ray effect on the protein antibodies of the blood is not understood at this time.

We feel that the action of x-rays on the vascularity of the inflammed area is the most important factor.

PHYSICAL FACTORS EMPLOYED:

It is our belief that x-ray therapy should be used only by those who have had considerable experience in its effects. Only those who have been made acquainted with its ill effects can handle it with the proper caution it descries. X-ray therapy is a two edge sword and it can kill as well as cure. The authors have had no personal experience in the production of ill effects in the treatment of benign and inflammatory conditions, but the literature is sufficiently full of such cases to make one very careful in the treatment of these conditions.

We are using so-called superficial and deep x-ray therapy of small and moderate doses in the treatment of inflammatory conditions. More detailed technical data are not given since we do not intend this to be a review of the literature or a syllabus of treatment.

BURSITIS:

The bursa associated with any joint in the body may become inflammed and painful. By far the most commonly seen by us is so-called subdeltoid bursitis which may be seen in the acute or chronic forms. It produces a rather characteristic clinical picture of tenderness in the subdeltoid region and the inability of the patient to posteriorly adduct or to abduct the involved arm. Calcification in the region of the shoulder joints (in the bursa) may or may not be present. It is probably more frequently seen in patients with bursitis than those who have no shoulder complaints and probably represents old inflammatory processes in the shoulder bursa and is seen in the same percentage of acute or chronic cases.²

After the diagnosis of bursitis has been made (a roentgen study of the shoulder is imperative since this condition may be simulated by degenerative arthritis or destructive lesions involving the bones of the shoulder) treatment of immobilization and analgesia should be earried out and x-ray therapy initiated. The treatment given consists of a moderate amount of deep x-ray treatment given over a three to five day course. The treatments are usually given through a rather large cone directed to the point of maximum tenderness in the shoulder or part of the body involved.

The beneficial effects observed are much greater with acute bursitis (having a history of two weeks to a month) than they are in eases of chronic bursitis (those having a longer history). Initially, an increase in the pain may be experienced, but after a few hours recovery usually starts and gratifying results are experienced. We feel that ninety percent of patients with acute bursitis may be cured or decidedly benefited by this treatment and about half this percentage of the chronic form may be cured or benefited.

Various other methods have been used in the treatment of bursitis and these include washing the bursa out, surgical extirpation, the injection of novocain and the usualization of diathermy. The use of x-ray therapy appears to be the modality of choice due to the relatively high cure rate and the lack of need for hospitalization.

CARBUNCLE:

X-ray therapy may be used as an adjunct to other forms of treatment in this condition. Penicillin and the other antibiotics have had miraculous affect upon carbuncles and this treatment with cleanliness, surgical incision when indicated and the application of hot and wet dressings after suppuration has taken place should be combined with deep x-ray therapy or highly filtered superficial therapy. We continue to believe that suppuration may be aborted by the early use of x-ray therapy and the course of the disease shortened by its use.

In this condition small portals of x-ray are used and we usually employ small doses of deep x-ray therapy daily for three treatments.

FURLINCLE:

Furuncles, particularly those seen in the face may likewise be aborted or their duration shortened by x-ray therapy with the treatment given in small doses of heavily filtered superficial therapy every day for two or three days.

GAS GANGRENE:

Due to the serious nature of this condition many surgeons now routinely advise deep x-ray therapy of about 100 r. twice a day for two days over a portal to include the involved site routinely in compound fractures. Roentgen therapy is probably of considerable value in the treatment of these conditions after infection has started. There is certainly no contraindication to the use of deep x-ray therapy in gas gangrene and the beneficial effects reported in it warrant its trial. It should, of course, be used in conjunction with the standard methods of treatment.

PAROTITIS:

Deep x-ray therapy in the treatment of acute postoperative parotitis offers a great deal and the patient's stormy post-operative course can be corrected in most cases by deep x-ray therapy. The therapy should be given immediately after the condition is recognized and when so done a good result may be anticipated. When deep X-ray therapy is used in conjunction with other modalities of the antibiotics, measures to produce increased salivation and even the probing and massaging of the parotid duct, good results may be anticipated.

In this condition deep x-ray treatments are given localized to the parotid area and small doses daily are given for three days.

SINUSITIS:

Chronic paranasal sinusitis and lymphoid hyperplasia of the nasopharynx with obstruction of the custachian orifices are both greatly benefited by deep x-ray therapy and the latter is also benefited by the use of a special radium nasopharyngeal applicator.

Sinusitis with its resulting morbidity is rather serious to all who have it especially since recurrent upper respiratory infections are so frequently seen in patients with chronic paranasal sinusitis. We feel that much benefit can be derived from treatment of patients with chronic paranasal sinusitis using deep x-ray therapy.

The treatment may be directly anterior posteriorly to treat the frontal sinuses, anterior ethmoids and maxillary antra particularly or it may be directed obliquely to the nasopharynx through the cheeks or to the nasopharynx from the lateral border of the face. The direction of treatment employed depends on the most seriously involved part of the upper respiratory tract. Small doses of deep x-ray therapy through a small portal every other day for three treatments may be employed if a single portal is used or through two portals for three treatments may be employed. A single series of treatments usually suffice if the deep roentgen

therapy is going to be of benefit, but one more course of treatment properly given may be employed without ill effect or danger.

The use of a specially designed radium nasopharyngeal applicator in the treatment of lymphoid hyperplasia of the nasopharynx is being used by us and is particularly indicated in cases of deafness due to lymphoid hyperplasia blocking the eustachian orifices. It also is of benefit in the treatment of chronic upper respiratory disease particularly when due to lymphoid hyperplasia in the nasopharynx.³

WARTS:

Warts anywhere in the body and particularly those scen on the feet (plantar warts) are usually benefited by x-ray therapy. We treat warts using doses of 500 r. (through a narrow portal—of 4 to 5 mm. diameter) of superficial therapy every three weeks for three treatments and also are using 100,000 international units of vitamin A daily during the course of this treatment. The patient may be immediately benefited by the removal of keratotic tissue above the wart with a callus file and the scraping will produce immediate relief of pain and allow the x-ray and vitamin A to better penetrate the tissues.

ACNE:

The treatment of acne vulgaris is probably one of the main reasons superficial and deep x-ray therapy in the treatment of benign conditions has fallen into disrepute because in the early days of x-ray many patients were unwittingly improperly treated and who subsequently had developed deforming and mutilating late radiation changes. We now use small doses of radiation in the treatment of acne and get as good results. We do not like to treat a patient with acne vulgaris unless almost all other forms of treatment have been tried and found to no avail. When this is the case treatment is given to the faee from a right and left portal. Small doses of moderately filtered superficial therapy are given weekly for eight to ten treatments. High doses of vitamin A are used in conjunction with this treatment. Sufficient benefit has been derived from the x-ray treatment in this benign condition to make us feel it extremely worthwhile because to the patient this is such a disfiguring condition that his entire emotional setup is usually disturbed by it. We do not feel that the x-ray treatment we use causes any harm but it must be used judiciously.

CONCLUSIONS:

We have reviewed the treatment of many inflammatory conditions with x-ray therapy and have done so to call attention to the fact that this modality is useful and overlooked in the treatment of many inflammatory conditions.

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Greenville, S. C.

- 1. Pendergrass, E. P., and Hodes, P. J., "Roentgen Irradiation in the Treatment of Inflammation," Amer. J. Roent, and Rad. Ther., Vol. 45, Pgs. 74-106, 1941.
- 2. Young, Barton R., "Rocntgen Treatment of Bursitis of the Shoulder," Amer. J. Roent. and Rad. Ther., Vol. 56, Pgs. 626-630, 1946.
- 3. Crowe, S. J., and Walze, E. M., "Irradiation of Hyperplastic Lymphoid Tissue in the Nasopharynx," J.A.M.A., Vol. 134, Pgs. 124-125., 1947.

The Management of Infantile Diarrhea and Dysentery

Thomas D. Dotterer, M. D. Columbia, S. C.

Diarrhea is a symptom complex and should not be thought of as a disease per se. There are several varieties of infantile diarrhea and dysentery. A large percentage of cases are caused by chemical means or intestinal fermentation or by the ingestion of a foreign protein.

The finger nail is considered the chief offender where diarrhea is concerned. Food, water and milk are rarely incriminated. Flies, formerly considered a menance in causing diarrhea, are not transmitters, this having been proved after culture studies from their legs. Food handlers are not too important from an etiological standpoint, except when they themselves are infected, however, hand to mouth is still considered the most important means of transmission.

Shiga organisms are seldom seen in this part of the world, but the Flexner group is predominant. The Salmonella group is also important and must be kept in mind.

Certain factors must be considered when a baby has diarrhea, such as proper food—the quality and quantity—and excessive clothing and overheating.

The formula should not be changed on the slight provocation of loose stools, but when the condition lasts over a period of twenty-four hours, then the formula should be modified. A sudden onset of explosive stools generally means dysentery. Usually fever is present with pus and blood appearing in the stools.

Facts from the history of the case are important. The number of stools and the character of the stools help formulate plans for management. In many instances, overfeeding, excessive fats or carbohydrates result in loose stools which disappear when one or both are eliminated. It is well not to prescribe a rich formula during the first two weeks of life with the bottle baby. An ounce of water before each nursing in the breast fed baby will frequently prevent diarrhea.

Formerly, the pediatrician emphasized the examination of the gross stool for fats and protein curds by smearing with a tongue depressor, but now it is better to study the specimen with the aid of the microscope to determine the presence of pus or blood cells. This is accomplished by mixing a small portion of the stool with water on a glass slide and examining microscopically.

The stool culture is also important and should be secured at the bedside, using a sterile cotton swab. The swab is inserted about one or one and a half inches into the rectum, then streaked immediately on a petri dish containing S and S Media. This culture must be sent to the laboratory at once, not allowed to stand or

remain on the ward. The majority of stool cultures are negative for pathogenic organisms, or do not give any definite information. When cultures are positive the stools should be sterilized by using cresol or creolin before being discarded.

The physical examination of the patient is of extreme importance. Much information is obtained as to the color, elasticity of the skin, parenteral infection, especially the throat and ears, facies, respiration, heart action, and body temperature. Dehydration must be considered as an emergency—it demands hospitalization.

From the biochemical viewpoint there are several facts to consider in diarrhea or dysentery. We should always try to use electrolyte fluids by month first, before the parenteral route, unless there is vomiting. The hemoglobin percentage is valuable in denoting the hydration of the patient. It is necessary, therefore, to know and to check the following points if the patient is to be treated adequately:

- 1. Proper intake and absorbtion of fluids.
- 2. Water loss in the urine.
- Loss of sodium chloride, potassium, calcium, and magnesium in stools.
- 4. Potassium loss due to tissue catabolism.
- 5. Excess calcium and phosphate loss due to acidosis.
- 6. Protein loss from starvation.
- 7. Absence of vitamins from low intake.

Acidosis develops as the result of two main factors at play:

- 1. Loss of alkaline gastro-intestinal secretions.
- 2. Accumulation of acid metabolic products due to dehydration and diarrhea.

Sodium chloride should be administered to spare body tissues as well as a means of defense. Other fluids used are Lactate Ringer's Solution, or two parts saline with 6 Molar Lactate. Sodium Bicarbonate (.7-0.9 gm. per kg. of body weight) with 6 Molar Lactate Solution will help in cases involving severe acidosis. Potassium may be added to take care of body cell destruction. but should be used cautiously—only in cases with severe dehydration — because of its toxic reaction. Potassium is given in combination with sodium by any route. It is not necessary to administer calcium in the acidodic state, however, it may be used later.

In a study of diarrhea of the new born, Amos Christie and Associates, of Vanderbilt University, describe the condition as very infectious and, in all probability, due to virus infection. The virus theory is open to debate and all authors do not agree that

^{*}Read before the Second District Medical Society.

the virus is a causative factor. Dr. Christie has called our attention to one important and definite finding in these patients. All the cases have a red or ulcerated condition of the tip of the tongue or gums. Usually, but not always, high fever is present. Infection occurs generally from an infected nurse, intern, obstetrician, or from the infant's mother.

If diarrhea develops in the newborn nursery, immediate steps must be taken to locate the focus of infection. All attendants in the nursery are questioned as to sore tongue, sore throat, diarrhea, or head cold. The baby should be isolated at once, preferably with the mother, and transferred from the obstetrical department to another floor in the hospital.

The prognosis is grave and the treatment must be heroic. Serum Globulin in 2 c. c. doses given intranuscularly deep into the buttocks is the prescribed treatment, but in many instances one seeks every means mentioned in the text books.

Prevention of infantile diarrhea is foremost when treatment is considered. Administering one ounce of water before each breast feeding assists considerably when the baby nurses too fast, or when the breast milk contains a high percentage of fat. It should be emphasized once more that the bottle baby should not be given a too rich formula during the first two weeks of life-more water and less milk. When diarrhea develops it is well to omit two or three feedings and use 5% sucrose or glucose with saline. If vomiting is not present, a formula in addition to solid foods such as pablum, fine hominy, cream of wheat, or apple sauce may be used. Other menas of treatment consists of using banana powder for the potassiom it contains, or by using ripe bananas, (1/3 banana per pound of body weight six to eight times per day). Cannod tomato juice is beneficial because of the sodium chloride factor. Protein hydrolysis is of value in patients with diarrhea when they are unable to take sufficient nourishment by mouth (1 gm. amino acid per gm. of protein or calcium casenate). Glucose is good in 5 or 10% solution for fluid, nourishment, and to prevent liver damage.

If persistent vomiting is present, all fluids are withheld orally.

Shock is counteracted by using 6 Molar Solution in saline or by using Ringer's Solution (10 to 40 c. c. per kg.). Severe cases must receive blood transfusion or plasma (10 to 40 c. c. per kg.). Water loss in the stools is controlled by using normal saline (150 to 200 c. c.) as hypotonic solution. Calcium is used either as the chloride or gluconate parenterally. This of course must be given slowly because of a possible toxic reaction. Vitamin K is administered for hemorrhagic tendency or bleeding. Sulfonamides are used in all patients where fever is present, or in cases in which diarrhea lasts longer than 24 to 48 hours.

Lactic acid mild or boiled skimmed milk are the formulae of choice. Sulfadiazine is the drug of choice and is used in conjunction with kaolin or pectin. Cremosuxadine (S&D) is excellent in full doses for the first 24 hours, then three grains per pound of body weight for several days after the stools approach normal.

Formerly, paregoric was not used in patients with high fever or in those showing toxic symptoms. However, it should be used for comfort of the patient. Paregoric is invaluable in relieving pain and controlling restlessness. Penicillin and streptomycin are fine in some cases, and are particularly valuable in salmonella infection.

In conclusion, the management of infantile diarrhea and dysentery has shown a marked improvement in recent years, and today we may be proud when we recall the ill effects and high mortality of a decade ago.

Advances in Orthopedic Surgery

George R. Dawson, Jr., M. D. Florence, S. C.

Most of the major advances in orthopedic surgery which are proving of permanent worth are many years old

FRACTURES

Better fixation with better fixation material constitutes the major advance in the treatment of fractures. Vitallium plates and screws cause no reaction, but they are a bit too brittle. Stainless steel causes practically no reaction and seldom breaks. This better fixation allows early ambulation with no pain and no casts, or early ambulation with smaller casts so that fewer joints are immobilized.



Figure (1) Fracture neck of femur: Fixation by a Smith-Petersen nail. No cast.

The Slader splint idea with an external bar connecting four pins is fifty years old. It is losing favor in many sites—as in the femur—the soft tissue moves about the top pin and some low grade infection not infrequently results. The idea of four pins and a short leg cast in a tibial fracture is excellent as here shown.

Thus the four figures show that major fractures of the lower extremity can be up and about on crutches within a few days with hips and knees mobile. Full weight bearing is not allowed until bony union takes place.

Presented at 1947 convention of S. C. Medical Association held at Myrtle Beach, S. C., May 6, 7 & 8, 1947.



Figure (2) Intertrochanteric fracture of the femur: Fixation by a blade plate. No cast.

HEALING TIME

Healing time may be a great deal longer in adult shaft fractures than previously supposed. Thus a tibial fracture at the mid and lower third may require many months for bony union to take place. Watson-Jones has had eight hundred cases of femoral shaft fractures without a non-union. Complete, uninterrupted inmobilization is the secret. Some of those were immobilized for a year; some for even two years.

KNOWLEDGE OF BONE HEALING

Soft, porous cancellous bone is superior to hard, dense cortical bone for bone grafting. Cancellous bone as found in the ilium is quickly united to the grafted area. Tibial cortical bone may take years to be fully assimilated. Small chips are generally superior to large grafts. Non-union in soft cancellous bone is extremely rare.

SPINE SURGERY

A great advance in orthopedic surgery is in spine surgery. A great advance in spine surgery is the ever widening application of a spinal fusion operation. A great advance in a spinal fusion operation is the realization that the first fusion operation, a Hibb's fusion (Figure 6)—a facet fusion with addition of



Figure (3) Fracture of the shaft of the femur: Fixation by two plates and screws. No cast.

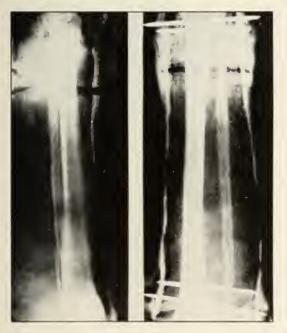


Figure (4) Fracture of the mid and lower third of the tibia and fibula: Fixation by two pins in upper fragment and two pins in lower fragment incorporated in a short leg cast.

small cancellous chips from the ilium or tibia—is superior to an Albee type massive cortical tibial graft. Clothespin grafts, wedge grafts, prop grafts, fixation by a plate between the spines, and screws across the





Figure (5) Intramedullary fixation is another fixation method; here, in a compound Monteggia's fracture (dislocation of radial head with nlnar shaft farcture) the ulna fracture is fixed by an intramedullary pin; the radial head is then reduced.

facets are all attempts to obtain better immobilization during fusion.

Spondylolisthesis and all types of unstable humbosacral mechanics can be relieved by this same type spinal fusion.



Figure (6) Shows dense Hibb's fusion, L-2 to sacrum for tuberculosis of L-3 and L-4. Following fusion, the diseased bodies themselves fused and healed.

Scoliosis, or lateral curvature of the spine, after correction can only be held permanently corrected by the same type fusion operation.

OSTEOTOMY OF THE SPINE

In cases of ankylosis of the spine in flexion following arthritis an osteotomy of the spine in the lumbar region has given a remarkable amount of straightening so that patients, formerly bent far over, can stand erect.



Figure (8) Scoliosis before correction.

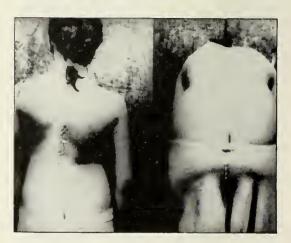


Figure (9) Scoliosis after correction and spinal fusion.

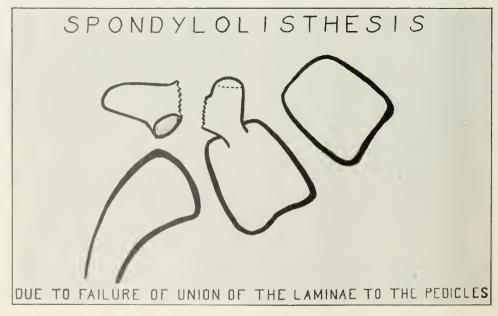


Figure (7) Spondylolisthesis L-5.

RELIEF OF LOW BACK PAIN & SCIATICA BY SPINAL SURGERY

Posterior protrusion of the fifth or fourth intervertebral disc material is a common cause of low back pain and sciatica. The first sacral nerve may be pressed upon or pulled on in its bony exit by unusual mechanics to give the same syndrome as a herniated disc. Removal of the herniated disc will give relief; a facetectomy may be necessary to relieve infringement upon the nerve at its exit. In either case, in addition to decompressing the spinal nerve a spinal fusion, L-4 to sacrum, should be done to give permanent relief.



Figure (10) Specimen (1) is a posterior protrusion of the nucleus pulposus removed at operation from the lumbosacral interspace. Specimen (2), on the right, is a ruptured annulus fibrosus removed from the fourth lumbar intervertebral disc space.

CONSERVATIVE TREATMENT

The treatment of acute low back pain and sciatica by flexion, that is, body, hips and knees slightly flexed, is often of greater benefit than is a "hard bed."

- 1. A paravertebral injection of L-4 or L-5 or both sometimes gives dramatic relief.
- 2. A novocain injection of trigger points in the back or buttock is occasionally of benefit but not as often as a paravertebral injection.

JOINT SURGERY

An arthrodesis of a weight bearing joint has always been and is still proving to be more satisfactory than an arthroplasty, notwithstanding vitallium cups and parts.

LEG EQUALIZATION

In the growing child, leg equalization can be obtained by excision of the epiphyses about the knee and also about the ankle joint in the longer leg. In the adult, it may be obtained by shortening the femir in the longer leg.

BRACHIALGIA

Brachialgia, or pain in the neck, shoulder and arm, is not infrequently caused by the so-called "scalene anticus syndrome" and can be relieved by myotomy of the scalene anticus uniscle. A posterior protrusion of a cervical intervertebral disc, usually between the fifth and sixth cervical vertebrae may also cause brachialgia. Head traction or removal gives relief.



Figure (11) Complete arthrodesis of the subtalar and ankle joints. The patient walks exceedingly well.



Figure (12) Femoral shortening of 23/4".

BONE TUMORS

Cysts, benign giant-cell tumors or chondromas can be cured by curettage and packing with bone chips.

MORTON'S TOE

Severe pain in the fourth toe, so-called "Morton's Toe," has been shown to be caused by a neuroma of the lateral division of the medial plantar nerve which supplies the third and fourth toes. Excision of the neuroma gives relief.



Figure (13) Decreased intervertebral dise space is site of posterior protrusion of nucleus pulposus.



Figure (14) Bone eyst of upper femur "Before," three months postoperative and one year post-operative.

Epidermal Sensitivity Due to Streptomycin

By George C. Smith, M. D. Florenee, S. C.

Few reports have appeared so far on the development of local sensitivity to Streptomyein. However, it seems reasonable to suggest that many more will be found in the future.

The report of Strauss and Warring in The Journal of Investigative Dermatology for August 1947 shows local sensitivity to Streptomycin developing in six out of twelve nurses working with this drug. As they state; "it would not be logical to assume that 50% of those using the drug will probably develop a sensitivity." Their work is rather complete in showing this to be a definite local reaction to Streptomycin. The use of controls, the graded concentration of the solution used for patch testing and the use of other antibiotics, in those cases showing Streptomycin sensitivity, for patch testing and negative results obtained support this contention.

Many conditions entered the ease here presented which prevented the writer from following their line of investigation. Failure to make photographs of the lesions and the outstandingly positive patch test reaction which occurred in my patient has no excuse. The details of the ease are given in the following summary:

N. A., a graduate nurse, has been employed in the Florence-Darlington Tubereulosis Sanitarium for the past eight years. She was first seen by the writer on October 16, 1947 and the involvement of the hands

and evelids in a subacute dermatitis was found. She began handling Streptomyein four months before being seen for the first time. For the past sixteen years she had had a ehronie recurrent dermatitis of the hands. Approximately three months ago there was a flare of the dermatitis of the hands and a dermatitis of the evelids soon followed. It was felt that she had a contact type dermatitis and upon questioning she stated that she had been giving Streptomycin and penieillin to the patients. I suggested that she remain away from her job for one week, during which time dermatitis cleared about 30%. Under simple local treatment she would show a partial remission but the flares continued each time she returned to work. Since she had not been told to discontinue the handling of Streptomyein she had proceeded to administer the drug to her patients. Food diary and dieting were tried with little success.

A test dose of 1:100 ambotoxoid was given with a 2×3 inch painful flare on the arm and a flare of the dermatitis of the hands occurred. Gradually increasing doses of ambotoxoid were given after the contact type dermatitis cleared.

The history revealed the incision and drainage of an abscess of the buttocks which had followed intranuscular quinine hydrochloride. At present there is a recurrence of the abscess which the patient has hesitated to have drained.

She was asked to bring a bottle from which Streptomycin had been used. A small amount remaining in the bottle was placed on gauze square and put under cellophane covered patch. Similarly penicillin, mercurochrome and jodine were used. The tests were read in forty-eight hours. None were positive, but the Streptomycin. The patient stated that itching was present in the area where the Streptomycin patch was placed within twelve hours. There was a four plus reaction to Streptomycin with marked vesiculation. There was a flare of the hands noted simultaneously with the positive patch test; the evelids having previously cleared, only showed a mild pruritus at this time. Since the positive patch test she has not handled any Streptomycin and the hands are the best they have been in months with no change in therapy having been made.

Eight nurses were patch tested to Streptomycin, full strength as given to the patients (100 mgm per cc.) and none showed a positive reaction. All of these nurses work in the Florence-Darlington Tuberculosis Sanitarium with N. A. They were also given a patch test to penicillin (20,000 units per cc.) with no positive reactions. Two persons never exposed to Streptomycin had negative patch tests.

In this case, the writer feels that the Streptomycin sensitivity has occurred more along the line of "widening of the base" of sensitivity which has been suggested by Stokes rather than as a primary cause of the dermatitis.

Although she continues to have some dermatitis on the hands, I feel that this is due to her previous difficulties and is unrelated to Streptomycin.

Comment

The fact that this patient showed a vesicular reaction to a patch test of Streptomycin while her fellow

workers handling Streptomycin, similarly, failed to show any reaction with the same concentration seems to establish the Streptomycin as the cause of a flare in this patient. The flare of the hands and eyelid in the patient which accompanied the reaction to the patch test further supports this contention.

As stated by Strauss and Warring, Sulzberger has said: "Whenever a reaction of the eczematous character is produced at the site of a patch test, provided the substance used is not a primary irritant, one may conclude that eczematous hypersensitiveness of the skin to this substance has been demonstrated." I believe I have supported Strauss and Warring's contention, that Streptomycin in the concentration used, is not a primary irritant, with the negative patch tests in eight nurses and two other persons.

It seems logical to assume that all persons continuing to handle antibiotics should receive a close check-up in the event they develop a contact type of dermatitis.

Conclusions

A case of local sensitivity (epidermal) to Streptomycin is reported.

The case occurred in a person handling Streptomycin while administering it to patients.

This is believed to have occurred on the basis of "widening of the sensitivity base" rather than a primary sensitization as a cause of the dermatitis present.

The writer wishes to acknowledge the help and cooperation of Dr. E. C. Hood and the Nursing staff of the Florence-Darlington Sanitarium.

References

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The Journal of the South Carolina Medical Association

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MAY, 1948

A LETTER TO OUR REPRESENTATIVES IN CONGRESS

When it was brought to our attention that in legislation now being prepared in Washington, aimed toward the reactivating of selective service, provisions were made for calling up men from the ages of 19 to 27, with the added provision that physicians, dentists, and veterinarians up to the age of 45 would also be subject to call, the following letter was sent to each of our representatives in the Congress:

"It is our understanding that in the legislation now being considered, aimed toward reactivating selective service, there is a special provision for calling up for service physicians, dentists and veterinarians, up to 45 years of age. This is the only group specifically mentioned in the proposed legislation.

"We feel strongly that this proposal would be unfair to the people of South Carolina and to the physicians. We realize that physicians and dentists are going to be needed for an increased Army, but we feel that the experience of World War II has shown the necessity for eareful selection of such physicians from among those in civilian practice. Here in South Carolina there was no difficulty in securing volunteers from the medical profession during the last war. In fact, our physicians had to be held back rather than urged to serve. At the same time we found that we had to be very careful as to which physicians were allowed to go into service and that the decision rested upon the location of the physician and not his age. For instance, a physician in a rural community, even though 38 years old, was declared essential to civilian practice, but his colleague in a large city, 40 years old, was declared available for military service. We feel that a plan modeled upon that of procurement and assignment, as it worked in World War II, is essential for protecting the people. We also feel that the proposal to subject physicians and dentists in the higher age group to draft and not to do the same with other professional groups and those with particular training is highly discriminatory. In view of these reasons, we would urge that you use your influence to see that this provision in the proposed selective service legislation is eliminated.'

STATE HEALTH COUNCIL

As this is written, plans have been completed for a state-wide meeting in Columbia to be held on May 6th, to which representatives from all organizations in the state, which directly or indirectly deal with matters of health, have been invited. These individuals are being invited to the meeting and to a luncheon as guests of our Association. The program will consist of several addresses, depicting various phases of health conditions in the state today, and of a general discussion of the best ways to improve these conditions.

This meeting is being sponsored by our Committee on Rural Health and we feel that this Committee should be commended for this effort.

All too frequently we, as an Association, have been praised for the work which we have done along scientific lines but have been criticized for failing to cooperate with other groups and organizations in working toward the common goal of better health for all our people. This meeting should help to dispel such criticism for it will lay the groundwork for the creation of a State Health Council.

The purpose of such a Council is to bring into one organization representatives of any and all groups who are striving toward making the people of South Carolina healthier. We need such an organization in this state. The health of our people is the paramount issue, not the desires or interests of any particular group or individual. There is strength in united effort—and such an effort can be achieved only through joint consultations and planning.

We sincerely hope that this meeting in Columbia will result in a strong and militant State Health Council—and we wish such a Council every good wish in the great task which is theirs.

C. M. A. B.

The C. M. A. B. (Cooperative Medical Advertising Burcau) was established by the Board of Trustees of the A. M. A. to serve as a central agency through which state medical journals could secure national medical advertising. There is at the present time an office for this Bureau in the A. M. A. headquarters in

Chicago with an executive director. The Bureau is under the control of the Board of Trustees of the A. M. A. But there is an Advisory Committee, composed of five editors or business managers of state medical journals, which works closely with the Board of Trustees and with the Director. (Your editor is privileged to be one of those five at the present time. and wishes to state that he has found the Board of Trustees highly cooperative in the meetings which he has attended.)

As is true of any such Bureau, there must be certain rules and regulations. One rule which the Bureau has adopted is that only those drugs which have been "accepted" by the Council on Pharmacy and Chemistry of the A. M. A. shall be advertised in the state medical journals which participate in the activities of the Bureau. This provision was agreed to by the Advisory Committee as being just-although at times the members of the Committee felt that the restrictions laid down by the Council on Pharmacy and Chemistry were far too stringent, and efforts were made to have some of these restrictions removed.

Adhering to this rule, our Journal along with most of the other state medical journals will not allow any advertising to appear in our pages which mentions drugs that have not been "accepted" by the Council on Pharmacy and Chemistry.

There are four state journals (Illinois, New York, California, and Rhode Island), however, which do not see the necessity for adhering to such a rule and these are not participating members of the Bureau. These journals prefer to have their own special committees pass upon the drugs which are offered for advertising, and to come to their own decision as to whether they will or will not be offered to their readers. Rather than to use the services of the C. M. A. B. for procuring advertising, they secure their own through their own

It is only natural that these two lines of thought and

of action should bring about an argument-ves, bitter argument. In a recent issue of the I. A. M. A., there appeared a strong editorial on the subject, in which the editor, mincing no words, called the four journals to task for the actions which they had taken. In the last issue of the Illinois Medical Journal came the counter-blast and, sparing no words, the editor defended his position and called the editor of the A. M. A. to task for the stand which he had taken.

No one cnjoys a good argument more than we do, and through the years we have participated in arguing this very question with great pleasure. And through this arguing, we have come to see clearly that there are merits and demreits on both sides of the question. It is not hard for us to see how spokesmen on either side can become worked up to fever heat when the subject is under discussion.

Yes, we enjoy a good argument. But we deplore this washing of dirty linen in public print. It is one thing to disagree with a man in his method of doing things, it is another to accuse him of ulterior motives.

What does the physician or the layman, who does not know the facts in the case, think when he finds the editor of the foremost medical journal in the world telling his readers that four of our leading state medical journals have cast aside their sense of right and have allowed financial greed to govern their acceptance of advertising copy, and then to read an editorial in one of our foremost state medical journals in which the editor accuses the editor of the J. A. M. A. of misrepresenting facts and of assuming the role of dictator. It certainly makes for disunity at a time when the members of the medical profession should be strongly united.

It is our sincere hope that these two editorials will be the last public airing of this discussion and that further argument, vituperative though it may be, shall be confined to the conference room where it belongs.

DEATHS

Dr. C. H. Able, 89, died at his home in Norway, March 28. Dr. Able was graduated from the Georgia Medical College at Augusta and practiced medicine at Norway for approximately sixty years before retiring several years ago.

Survivors include his widow, Mrs. Nan Brennecke Able, one son, Dr. E. G. Able of Newberry, and two

daughters.

DR. RUPERT BLUE

Dr. Rupert Blue of Marion, retired public health official, died April 12 in a Charleston hospital. A former surgeon general of the United States Public Health Service, Dr. Blue was credited with discovering that fleas on rats were responsible for carrying bubonic plague,

THE TEN POINT PROGRAM

STATE HEALTH CONFERENCE

In making the plans and arrangements for the statewide Conference on Health, held in Columbia on May 6th, the Rural Health Committee of the South Carolina Medical Association, Dr. II. S. Gilmore, Chairman, has made a valuable contribution toward the advancement of the Ten Point Program. It is doubtful if any other one project could have been more in the interest of good public relations of the medical profession.

Twenty-three organizations in the State interested directly or indirectly in health or the care of the sick, including some departments of the State Government, professional Associations and eivic groups, were invited to participate. Each of the groups was requested to send three representatives to take part in the all-day Conference at the Wade Hampton Hotel and to be the guests of the South Carolina Medical Association at luncheon. As of this writing, approximately half of those invited have replied and none has failed to indicate its intention to be represented.

Seven leaders in various phases of organizational work pertaining to health were invited to speak. The general plan of the program was to offer presentations by qualified speakers, on problems peculiar to various segments of the population in South Carolina, and suggestions as to any possible solutions. Following the presentation by each speaker, a brief discussion period was planned.

Plans of the Rural Health Committee, in setting up the meeting, looked forward to the possibility of having it serve as the nucleus of a State Health Council, similar to organizations already operating in North Carolina and a number of the other states. The idea has been under consideration in South Carolina since the Ten Point Program was instituted. This, however, is the first concrete move in that direction. It was not the intention of the Committee on Rural Health to attempt alone, the organization of such a Council, and a Conference such as that planned for May 6th seemed to be the ideal medium for determining the sentiment of representative groups in the State toward such a move, and to allow the opportunity for such preliminary planning as might be indicated.

After round-table discussion, which was planned for the closing hour, the conferees were to discuss the need and desirability for the formation of a Health Couneil, and make tentative plans for such an organization if decided upon. Such a representative group is the logical starting place for a movement of this kind. Without representation and support on a broad base, it could not hope to succeed, and, even if the group meeting in Columbia on May 6th should reach the conclusion that no useful purpose can be served by the organization of a State Health Council, the time and effort to arrive at such a conclusion and to air the views of the various groups represented there will have been well spent.

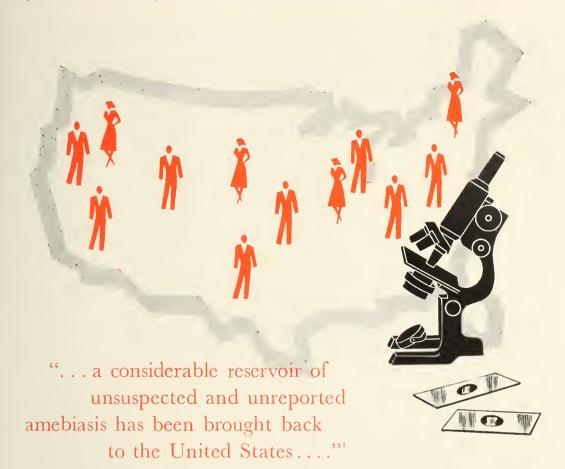
Congratulations to Dr. Gilmore and his Committee!

THE NATUROPATHIC INVESTIGATION

Perhaps the most disappointing feature of the legislative session which recently adjourned, was its failure to adopt an effective Resolution for the investigation of the Board of Naturopathie Examiners in South Carolina. The fate of the Resolution, proposed in 1947, has been so oft-repeated that the story must be boring to our readers. Having passed both the House and the Senate last year, it suddenly disappeared in the last days of the session and has never since been heard of. In 1948 an identical Resolution was introduced in the House of Representatives and, after a few days, was adopted by that body and sent to the Senate. There, it was promptly referred to the Senate Committee on Medical Affairs.

Despite efforts to have it considered immediately, the Resolution was held up for several days. The Naturopaths requested a Hearing, to which, of course, they were entitled, and the Hearing was held by the Committee. The Naturopaths were well represented and through the Secretary of their Board of Examiners, their attorney, Mr. Theodore of Columbia, and several others, presented their case. No action was taken at this meeting, a vote being deferred until the Committee should have opportunity to hear the statement from Captain Legare Ansel of the Office of Law Enforcement, who assisted State Police Officers from Connecticut in an investigation last year.

Mr. Ansel appeared and testified before the Committee on April 6th. The nature of the information which he had to divulge at that time from his files, based upon his findings, and the inability to find certain records in the files of the Board of Examiners, seemed to impress the Committee with the urgent need for remedial action. As was proper, however, they held the matter open for a day longer in order to allow the Secretary of the Naturopathic Board an opportunity to answer the report made by Captain Ansel, Dr. Branyon of Spartanburg, Secretary of the Board, was notified to be present with his records on the following day. He appeared with several other members of his profession and made explanations similar to those made on their behalf at the first Hearing.



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- Editorial: The Problem of Amebiasis, J.A.M.A. 134:1095 (July 26) 1947.
- Wilbur, D. L., and Camp, J. D.: Amebic Disease of the Cecum: Clinical and Radiological Aspects, Gastroenterology 7:535 (Nov.) 1946.
- Morton, T. C. St. C.: Diodoquin for Chronic Amoebic Dysentery in Service Personnel Invalided from India, Brit. M.J. 1:831 (June 16) 1945.

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The Naturopaths took the position before the Senate Committee, that they deplored any improper activities on the part of any member of their profession, but that they were powerless to revoke licenses or take any remedial action. It was stated that they have ceased issuing licenses on a reciprocal basis to applicants previously licensed in Tennessec, since that state outlawed the practice and the issuance of licenses there. They requested the Committee's assistance in providing them with some means to clean their own house and this the Committee finally decided to do.

It was clearly evident that the members of the legislative bodies had been subjected to strong pressure by the Naturopaths and their friends. A printed pamphlet placed on the desk of every Honse member early in the session was ample evidence of their awareness of the danger which threatens their practice, their ability and willingness to fight for a continuation of the status quo, and the fact that they have the means to do so.

They were successful this year to the extent that the Senate Committee on Medical Affairs finally, in the very last days of the session, disposed of the matter by substituting in place of the provisions for an investigation by a joint legislative committee, a direction that such investigation be conducted by the Board of Naturopathic Examiners themselves. The text of the Resolution is carried elsewhere on this page. In adopting it, upon the Committee's recommendation, the Senate and the House of Representatives recognized the existence of a deplorable situation in the State. At the same time they expressed their confidence in the ability and willingness of the Naturopaths themselves to correct it. While we are far from optimistic as to the possibility of any concrete action by the Board toward any of their practitioners, the Resolution makes it their duty to take into account the information already obtained by the Law Enforcement Office Investigators and to report back to the General Assembly at its opening session next year. While little of consequence can be expected in 1948, perhaps this Resolution may prove to be the foundation for some definite legislative action in the future, to prevent the people of South Carolina from being victimized at the hands of unqualified pretenders to the title: "praetitioners of the healing art."

THE RESOLUTION

"That the Board of Naturopathic Examiners of the State of South Carolina do immediately undertake a study of the various licenses, and personal qualifications of applicants heretofore licensed to practice Naturopathy in this State and the propriety of cancelling any licenses erroneously obtained, and to that end:

"The Board of Naturopathic Evaminers of the State of South Carolina are hereby authorized and directed to immediately cancel any licenses of licensees to practice the profession of Naturopathy, if said Board in their discretion decides that said licenses should be cancelled for any reason; and in checking the qualifications of the licensees the said Board shall take into consideration the information as said Law Enforcement Division may be able to obtain with reference thereto;; and

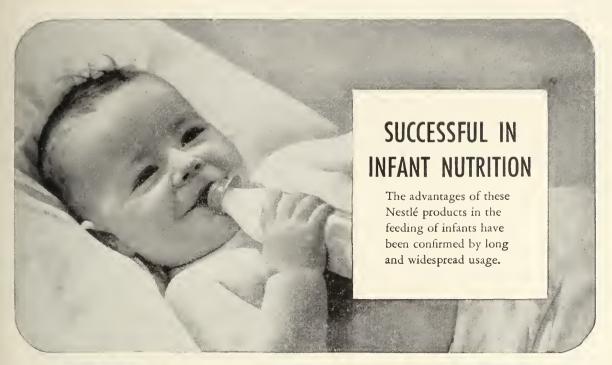
"BE IT RESOLVED FURTHER that the Board of Naturopathie Examiners of South Carolina submit to the General Assembly of South Carolina on its opening day in January, 1949, a full and complete written report concerning the matter and things set forth herein."

INDUCEMENTS TO RURAL PRACTICE

The Legislature at its 1948 session, passed a law providing for the establishment of eight scholarships at the Medical College of South Carolina, to be financed through State appropriations. The scholarships will be allotted, one in each Congressional District in the State, of which there are six, and two at large. Beneficiaries will be those young men and young women throughout the State who are able to pass the entrance requirements and meet the other qualifications set up by the authorities in charge of admissions to the Medical College, who are willing to agree to practice for limited periods in a rural community in South Carolina, following graduation and internship.

The Bill had the sponsorship of the Board of Trustees of the Medical College. In fact, it was prepared under the direction of a sub-committee from the Board. As originally drawn, it would have provided for six seholarships. The number was increased by the Legislators. The value of these scholarships is considerable. They will provide free tuition together with \$75.00 per month to defray the expenses of board, lodging and other living costs, during each of the eight months of the school session. The eight scholarships would be awarded each year, so that it would be possible for a beneficiary to enter and complete his entire medical training course at the College through this means. In order to have the benefit of the scholarship thus provided, the student will be required to contract in advance to practice in a rural community one year for each seholarship year. The rural community will be designated by the State Board of Health on the basis of data and information contained in its files, indicating the need for medical service in such communities. In the event the student should fail to comply with his part of the contract after having received the benefits of the scholarship, any amount remaining due by him because of unserved time in rural practice would be immediately due and collectible by the Board of Trustees.

The fact that the Bill had comparatively little opposition, indicates the awareness of the Legislators,





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generally, to the need for more doctors in the country, and their willingness to cooperate by furnishing State funds in order to try to boost the supply. A similar bill by Senator Rivers of Chesterfield County, providing for 46 scholarships, one for each county in the State, did not receive a favorable report by the Senate Committee on Education, to which it was referred. The provision made by the Bill which was passed however, is a good start in the right direction. If it proves attractive to young students, no doubt the Legislature will be willing to go along and, in fact, will be anxious to do so by providing additional scholarships in future years.

Such steps as these are concrete examples of the intention and ability of free economy to solve its own problems. The Board of Trustees of the Medical College and the members of the General Assembly are to be congratulated on their vision and their willingness to act. It is gratifying to find South Carolina in the vanguard of progress in this field. According to information recently carried in the Journal of the American Medical Association, it is one of only seven states which have already provided for such scholarships.

The monetary value of the provisions made by South Carolina, as indicated above, compares favorably with the value of the scholarships established in other states which have made such provisions.

NATIONAL HEALTH ASSEMBLY

The announcement on last February 13th by the newly-appointed Federal Security Administrator, Mr. Osear R. Ewing, of plans for holding a National Health Conference or Assembly in Washington, May Ist to 4th, was evidence of his intention to effectuate, to some degree at least, the suggestion by the President in his message which preceded the announcement by a few weeks. A ten year health program is to be outlined and the attendance of some 800 delegates is expected. Unfortunately, information, as this is written, is to the effect that accommodations will be so limited that there will be little chance for representation of many State Medical Societies at the meeting. On the other hand, it appears that the State Public Health Agencies, all of which are directly connected with the U.S. Public Health Service, a department within the Federal Security Administration under the present set-up, will be well represented, both among the conferees and on the speaker's platform.

Among the things probably to be considered by the convention, according to a subsequent statement by Mr. Ewing, will be these: (1) Grants to medical schools for operating expenses, (2) Grants for construction of new buildings and additions to existing buildings, and (3) A scholarship program to increase the number of persons training for medical and other related health services to the nation. It is understood

that the annual grants which Mr. Ewing will propose, to implement the plans to assist medical schools in defraying operating expenses, will be approximately fifty million dollars. Under the scholarship program, both state scholarships, such as those recently provided in South Carolina and several other states, will be advocated, and paralleling this, national medical scholarships, under which likewise, doctors would agree to serve for a time in special shortage areas. A number of the doctors receiving benefits under this latter type of scholarship would doubtless be expected to serve in certain of the Federal Government Agencies, such as the Veterans Administration, the Public Health Service, the Army or the Navy. The Conference will be held during the interim between this writing and its publication. We bespeak for it the utmost success and hope that its conduct will prove that in the United States, under the sponsorship of the Government Agencies, it is possible to have a truly democratic and free discussion of ideas, regardless of whether or not they coincide with the ideas known to be held by the heads of Government themselves.

HEALTH BOARD REORGANIZATION BILL

Below is the complete text of the Bill proposed by the Senate Committee on Medical Affairs and introduced in the South Carolina State Senate at the recently adjourned session of the General Assembly. The Bill, in this form, received two readings in the Senate. It was then referred on motion of Senator Abrams, of Newberry, to the newly created Reorganization Commission, for study.

This Bill is not law. Presumably, it will receive consideration by the Commission during the current year and the Commission may recommend its passage by the Legislature in this or some modified form, in 1949.

It will remain therefore a matter of current interest during the coming months, and is carried in full here so that all members of the Association may have the opportunity to become informed as to its provisions.

A BILL

To create and Maintain the South Carolina Board of Health; to Prescribe the Duties of Said Board; to Provide for the Selection and Appointment of Its Members; to Devolve All the Rights, Powers, Duties, Etc., Now Vested in the State Board of Health and the Executive Committee Thereof Upon the South Carolina Board of Health; to Provide for the Organization, Regular Meetings and Reports of the Said Board of Health; to Create the South Carolina Department of Health to be Under the Control of the South Carolina Board of Health and to Prescribe Its Duties and Provide for Its Operation Under the Direction of the State Health Officer, and to Provide for Annual Re-

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Zondek, H.: The Diseases of The Endocrine Glands, ed. 4 (Second English), Baltimore, Williams & Wilkins Company, 1944, p. 421.

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ports of the State Health Officer and Further Prescribe His Duties.

BE IT ENACTED by the General Assembly of the State of South Carolina:

SECTION 1. That there is hereby and herewith created and established, the South Carolina Board of Health, consisting of eleven (11) members, appointed and commissioned by the Governor as hereinafter provided and set forth.

SECTION 2. That all the rights, powers, duties and responsibilities now vested in the State Board of Health and the Executive Committee of the State Board of Health, are hereby and herewith transferred and vested in the South Carolina Board of Health.

SECTION 3. That the Governor shall appoint and commission the members of the South Carolina Board of Health, as follows: six (6) physicians, one (1) dentist, one (1) registered nurse, one (1) graduate pharmacist, one (1) hospital administrator, and one (1) other citizen of the State, who shall not be a physician, dentist, registered nurse, registered pharmacist, or hospital administrator. That all members of the Board shall be appointed as herein provided: That one (1) physician be appointed for a term of one (1) year; that one (1) physician, and one (1) hospital administrator be appointed for a term of two (2) years; that one (1) physician, and one (1) registered nurse be appointed for a term of three (3) years; that one (1) physician, and one (1) graduate pharmacist be appointed for a term of four (4) years; that one (1) physician, and one (1) dentist be appointed for a term of five (5) years; that one (1) physician, and one (1) citizen be appointed for a term of six (6) years. All such appointments to date from the last Friday in June 1948, that appointments subsequent to that date, except for the filling of unexpired terms, shall be for a period of six (6) years and until a successor is appointed and qualified, and shall be made from the same categories respectively and in the same manner as those of the original appointees as above provided; that except members who have not served for as long as twenty-four (24) months, no member may be appointed immediately to succeed himself or herself but may again be appointed a member of the Board after one (1) year absence from such membership; that when a vacancy occurs, other than through expiration of terms of appointment, the person appointed shall be qualified within the category in which the vacancy occurs and his or her term of office shall be the unexpired term of office of the person whom he or she shall succeed; and if this unexpired term shall be twenty-four (24) months or more, the member who fills it shall be considered as having served the equivalent of a full term insofar as concerns eligibility for future appointment. Members of the Board of Health shall be removable by and at the pleasure of the Governor for neglect of duty and other causes after a hearing by the Board, when at least seven (7) members of the Board certify to the Governor in writing that such a hearing has been held, and that they believe the charge or charges which they shall set forth, have been sustained and are sufficient cause for removal; *Provided*, that no member shall be removed from the Board of Health unless thirty (30) days before the hearing of charges, he or she shall have been advised, in writing, of the specific charge or charges against him or her and of the time and place for such hearing.

SECTION 4. That the South Carolina Medical Association, at its first meeting after January 1, 1948, shall elect six (6) members to be recommended to the Governor, on or before the next ensuing first Friday in June, and the Governor, on or before the next ensuing last Friday in June, shall appoint and commission said six members, with others as set forth, to constitute the Board of Health, and the Governor shall designate the term for which each of the six (6) shall be appointed, as herein provided; that at each annual meeting subsequent to the first (1st) of January 1949, the South Carolina Medical Association and their successors, in their corporate capacity, shall elect one (1) member to be recommended to the Governor on or before the next ensuing first Friday in June of each succeeding year, and the Governor, on or before the next ensuing last Friday in June of each succeeding year, shall appoint and commission said member to serve as a member of the South Carolina Board of Health, for a period of six (6) years.

SECTION 5. That the South Carolina Dental Association, at its first meeting after January 1, 1948. shall elect one (1) member to be recommended to the Governor on or before the next ensuing first Friday in June, and the Governor, on or before the next ensuing last Friday in June, shall appoint and commission said member, with others as set forth, to constitute the Board of Health; the Governor shall designate the term of office as five (5) years; that at each sixth (6th) annual meeting, subsequent to January 1, 1953, the South Carolina Dental Association and their successors in their corporate capacity, shall elect one (1) member to be recommended to the Governor on or before the next ensuing first Monday in June of each succeeding sixth (6th) year, and the Governor, on or before the next ensuing last Friday in June of each succeeding sixth (6th) year, shall appoint and commission said member to serve as a member of the South Carolina Board of Health, for a period of six (6) years.

SECTION 6. That the South Carolina Nurses Association, at its first meeting after January 1, 1948, shall elect one (1) member to be recommended to the Governor on or before the next ensuing first Friday in June, and the Governor, on or before the next ensuing last Friday in June shall appoint and commission said member for a period of three (3) years, to serve with others as set forth, as the South Carolina Board of Health; that at each sixth (6th) annual meeting subsequent to January 1, 1951, the South Carolina Nurses Association, and their successors, in their corporate



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capacity, shall elect one (1) member to be recommended to the Governor on or before the next ensuing first Friday in June of each succeeding sixth (6th) year, and the Governor, on or before the next ensuing last Friday in June of each succeeding sixth (6th) year, shall appoint and commission said member to serve as a member of the South Carolina Board of Health for a period of six (6) years.

SECTION 7. That the South Carolina Pharmaceutical Association, at its first meeting after January 1, 1948, shall elect one (1) member to be recommended to the Governor on or before the next ensuing first Friday in June, and the Governor on or before the next ensuing last Friday in June shall appoint and commission said member for a period of four (4) years, to serve with others as set forth, as the South Carolina Board of Health; that at each sixth (6th) annual meeting, subsequent to January 1, 1952, the South Carolina Pharmaceutical Association, and their successors, in their corporate capacity, shall elect one (1) member to be recommended to the Governor on or before the next ensuing first Friday in June of each succeeding sixth (6th) year, and the Governor, on or before the next ensuing last Friday in June of each succeeding sixth (6th) year shall appoint and commission said member to serve as a member of the South Carolina Board of Health for a period of six (6) vears.

SECTION 8. That the South Carolina Hospital Association, at its first meeting, after January 1, 1948, shall elect one (1) member to be recommended to the Governor on or before the next ensuing first Friday in June, and the Governor, on or before the next ensuing last Friday in June shall appoint and commission said member for a period of two (2) years, to serve with others as set forth, as the South Carolina Board of Health; that at each sixth (6th) annual meeting subsequent to January 1, 1950, the South Carolina Hospital Association, and their successors, in their corporate capacity, shall elect one (1) member to be recommended to the Governor on or before the next ensuing first Friday in June of each succeeding sixth (6th) year, and the Governor, on or before the next ensuing last Friday in June of each succeeding sixth (6th) year shall appoint and commission said member to serve as a member of the South Carolina Board of Health for a period of six (6) years.

SECTION 9. That on or before the last Friday in June 1948, the Governor shall appoint one (1) citizen of the State, who shall not be a physician, dentist, registered nurse, registered pharmacist, or hospital administrator, who with others as set forth, shall constitute the South Carolina Board of Health; the Governor shall appoint and commission one (1) such citizen for a term of six (6) years; that on or before the next ensuing last Friday in each succeeding year after January 1, 1954, the Governor shall appoint one (1) such citizen for a term of six (6) years to succeed the citizen originally or subsequently appointed under

the terms of this Act, to serve the term of the citizen expiring in each succeeding sixth (6th) year; and that when vacancies occur in this category of the membership of the South Carolina Board of Health, other than through expiration of term of appointment, the Governor shall, within his discretion, and in not less than thirty (30) days, appoint a citizen of the State to fill the vacancy.

SECTION 10. That if the said South Carolina Medical Association, the South Carolina Dental Association, the South Carolina Nurses Association, the South Carolina Pharmacentical Association, and the South Carolina Hospital Association fail or refuse to make recommendations to the Governor as set forth, then the Governor shall, within his discretion, appoint physician members of the Board, dental member of the Board, registered nurse member of the Board, pharmacist member of the Board, and hospital administrator member of the Board, as may be necessary.

SECTION 11. That the South Carolina Board of Health, as provided for herein, shall meet on the first (1st) Friday in July, 1948, shall proceed to organize and elect a Chairman and Vice-Chairman, and are hereby empowered to adopt by-laws for the conduct of its business, and to amend such by-laws. The Board shall meet once in each quarter and at such other times when called by the Chairman or at the request of five (5) members of said Board. It shall fully and completely record its actions and shall carefully preserve its records. The Board shall render an annual report to the Governor and the General Assembly. Members of the Board shall be entitled to such compensation and reimbursement of expenses as may be provided by law.

SECTION 12. That there is hereby and herewith created and established the South Carolina Department of Health which shall be under the control of the South Carolina Board of Health. The South Carolina Department of Health shall have all the rights, powers, duties and responsibilities prescribed by law and as may be legally prescribed by the South Carolina Board of Health and such further rights, powers, duties and responsibilities usually pertaining to Organizations of like character. The South Carolina Department of Health shall be under the direction of the State Health Officer and it shall be the duty of the State Health Officer, appointed and holding office as now provided by law, to perform the duties and functions required of him under the existing laws of the State of South Carolina and to administer the activities of the South Carolina Department of Health as constituted under the terms of this Act and under the direction of the said Board of Health, to whom the State Health Officer shall be at all times responsible, and it shall be the duty of the State Health Officer to see that all acts relating to the public health are enforced, subject to the direction and authority of the Board of Health as herein constituted. He shall be responsible for en-



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forcement of public health laws enacted in the future and for the enforcement of all regulations of the Board of Health now existing or which the Board may in the future promulgate. He shall submit an annual report to the State Board of Health and the said Board shall transmit the same to the Governor along with, or incorporated as a part of, the annual report of the said Board of Health.

SECTION 13. All Acts or parts of Acts inconsistent with the provisions of this Act are hereby repealed, and specifically, Sections 4997, 4999 and 5222, are repealed.

SECTION 14. This Act shall take effect upon its approval by the Governor.

ABSTRACTS

Davies, J. W.; Bartholin Cyst, A Simple Method For Its Restoration To Function,

Surg., Gyn., Obst. 86:329, March 1948

Lying beneath the labia minora, the Bartholin gland secretes a clear, viscid fluid through its ostium, located superficial to the hymen. The purpose of the secretion is to lubricate the vulva and usually the amount of secretion is indicative of the interest in mating.

As a rule infection of the gland results in the formation of a cyst or localized abscess, but extension of the infection is rare. This disease of the gland is seldom venereal in origin, as has been proven by cultures and smears. The infective process usually begins in the minute duct of the gland, thus obstructing the excretion and causing cyst formation. Microscopic and anatomical studies show that this cyst is confined to the duct of the gland and not the gland proper.

Surgical excision of the cyst causes dyspareunia in many cases, due to the dryness of the parts. Therefore, the author has changed his treatment from that of complete removal of the cyst to one of ample drainage and the construction of a permanent opening which would completely drain the diseased duct and permit the remaining secretory cells to regenerate and function. Twenty-five cases were treated by an incision close to the hymen in the region of the opening of the duct. The cavity of the cyst was then packed with iodoform gauze which was removed and replaced biweekly for approximately three weeks. The packing prevents the small incision from agglutinating and permits squamous epitheliazation of the new ostium. Occasionally, this ostium may contract and necessitate opening with a blunt instrument. The restoration to normal was verified by the disappearance of the mass and the presence of a clear, viscid excretion.

This procedure is usually performed in the office under local anesthesia. Confinement to bed is not required. Treatment Of Arthritis By Intra-Articular Injection By D. M. Baker and M. S. Chayen Lancet 1: 93-96 (1948)

For patients with osteo-arthritis there seemed until recently to be little to offer between palliative treatment and major surgery. Many of these patients are either unsuitable for surgical measures or suffering from a condition not really serious enough to justify major procedures. It was in an attempt to fill this gap that the authors decided to try the treatment first suggested by Waugh, using the solution of lactic acid which he recommended, and later to assess the value of this fluid against alternative solutions.

Cases were selected on a very wide basis, and were either—osteoarthritis or rheumatoid arthritis.

Fifty-two cases were treated long enough to assess the results. Most of them were observed for six to eighteen months. The number of injections given to each patient ranged from two to twenty-two and the average number of injections was 10. Hips, knees, shoulders, and thumbs were treated. Two kinds of joints were treated: (1) Those in which the range of movement was full or nearly so but in which the patients disability was due to pain, and (2) those in which the disability was due to limitation of motion in addition to pain.

In all cases the diagnosis and the extent of the arthritis were confirmed by radiography. In the early stages of treatment injections were given fortnightly, later the frequency was usually reduced. When maximal improvement had apparently taken place it was often necessary to continue occasional injections to prevent regression.

The authors describe the procedure of injecting the fluid into the joints. The quantity of fluid they used varied from joint to joint, but 10 ml. was usually adequate for hips and knees, 5 ml. for shoulders, and 1 ml. for thumbs. As the effect of procaine began to wear off, there was often a transitory pain reaction. These reactions seemed to develop particularly where the range of joint motion was still improving.



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Literature on request



They are due possibly to a breakdown of adhesions, or to the fact that areas of disused joint surfaces are again playing a part in the weight-bearing functions of the joint. The solutions used were lactic acid in a 2% procaine solution; in another group 0.5% procaine adjusted to pH of 7.6%; and in a third group, normal saline was used. There was apparently a higher percentage of final improvement when lactic acid was used, though the authors think their results inconclusive in this respect. They have so far found no evidence that intra-articular injections with acid fluid has any special advantage over solutions in which the pH is physiological.

Two of the solutions used contained procaine and much of the value of the treatment may depend on this. This is especially true of patients who after a very few injections have become symptom free. They believe that such patients may have broken down their adhesions while the joint is still anesthetic. Dr. Baker and Dr. Chaven are becoming more and more convinced that most of the benefit is the result of lubricating action of the fluid. The recurrence of symptoms towards the end of a fortnight would eorrespond to the absorption of fluid and the resumption of the original dry state of the osteo-arthritic joint surface. Attempts are being made to find a fluid with a high osmotic pressure and viscosity, which will be retained longer within the joints and therefore, not require so many injections,

A great deal of benefit may be explained by a change in the mental attitude of the patient where he has received treatment which he believes to be good. Apart from injections there was no suggestion that the patient not include in his usual daily occupation and duties. He should be encouraged to carry on with his work and to do as much as possible.

While this is a comparatively small series, the authors are enabled to shape definite conclusions and they are extremely enthusiastic about the value of the treatment.

Management of Gastro-Intestinal Bleeding

By G. W. Horsley

Virginia Med. Monthly. 75: 17-19 (1948)

Correct diagnosis as to site and cause of gastro-intestinal bleeding is essential to proper management. The author divides the gastro-intestinal tracts into five portions and enumerates the chief eauses of bleeding in these areas as follows: (1) esophagus—diverticulum, ulcer, varices, cancer; (2) stomach—ulcer, gastritis, benign polyp, malignancy; (3) duodenum — nlcer, diverticulum, polyp; (4) jejunum and ileum — diverticulum, polyp, and malignancy; (5) colon and rectum — nlceration, polyp, diverticulum, malignancy and hemorrhoids.

About 75% of all gastrointestinal bleeding is due to peptic older and bleeding from the large bowel and

Dr. Horsley confines his remarks chiefly to these conditions.

Bleeding from esophageal varices presents a difficult diagnostic and therapeutic problem. Injection of the varices with a sclerosing solution gives excellent results in some cases. In patients who are good surgical risks, dissection of the varicosities at the terminal portion of the esophagus and ligation of the eoronary vessels at the gastro-esophageal junction is preferable.

The treatment of bleeding of peptic ulcers is dependent on the age of the patient. If the patient is under 45 and gives no history of previous bleeding, medical treatment is preferable.

If the patient is over 45, or if bleeding is recurrent the treatment should be directed toward proper preparation for operation.

Reassurance of both patient and his family is essential. Strict bed rest is prescribed, and ambulation should not be permitted until the bleeding has been controlled several days. It is inadvisable to try to restore blood pressure to normal limits but the patient must be kept out of shock. Supportive measures such as infusions, transfusions, oxygen and sedation should be used.

The patient should be hospitalized if possible. Small amounts of water during the first 24 hours are all that the authors permits his patients by mouth. Vitamins B and C are administered. Transfusions are given when systolic pressures fall below 100.

Dr. Horsley recommends lavage of the stomach if bleeding continues as collapse of the stomach reduces distention and bleeding.

After the initial period of withholding food, his patients are started on a regular peptic ulcer diet. Daily transfusions are given until the blood picture returns to normal with a hemoglobin of 13.5 grams and an erythrocyte count of 4,000,000 cu. mm.

If the patient is over 45 years old or if bleeding is recurrent, it is recommended that he be operated on and the ulcer or other cause of bleeding removed. As far as possible the ulcer should be excised no matter what type of resection is done. Vagotomy is not recommended.

Bleeding from the large bowel is frequently found. Digital and proctoscopic examinations should be made. When bleeding is from hemorrhoids this can be easily seen by annscope or proctoscopy and controlled by packing or operation. Dr. Horsley states that injections of selerosing solutions may be all that is necessary. Bleeding from points higher in the bowels is not apt to produce shock.

As soon as the patient's condition permits, roentgenological examination should be done and treatment directed toward the bleeding area. If the condition is an ulcerative colitis, the treatment is almost medical. If it is a neoplasm, benign or malignant, it should be removed surgically.



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The Value Of Chest X-Ray Survey In The Diagnosis of Cardiovascular Disease

A chest X-ray survey may be of considerable value in the discovery of heart disease in addition to abnormal pulmonary conditions. There are various cardiac lesions which may cause changes in the contour of the cardiac silhouette or in the prominence of the great vessels. It is true that individuals with a serious heart disease such as arteriosclerosis of the coronary arteries may have entirely normal cardiac shadows in the X-ray film. Certain cardiac abnormalities which are detected by other forms of radiologic examination may not be apparent on the posterior-anterior view obtained in the routine chest film. Although it must be admitted that the X-ray survey cannot be 100 per cent effective in detecting individuals with cardiovascular disease, it may be a very useful device.

Enlargement of the left ventricle may be detected by the chest X-ray and may be due to any one of the following causes: hypertensive heart disease, arteriosclerotic heart disease, chronic rheumatic valvular heart disease with aortic stenosis and or insufficiency, luetic aortic insufficiency and other less common cardiac lesions. Localized enlargement of the lower left cardiac border may be found in aneurysm of the left ventricle following coronary thrombosis with myocardial infarction. Right ventricular enlargement may be manifested by an increase of the heart shadow to the right of the midline. Commonly, however, moderate or even marked enlargement of the right ventricle may cause an increase in the heart shadow to the left. The postcrior-anterior projection does not always, therefore, in itself give adequate information as to which chamber of the heart is enlarged.

An increased prominence of the pulmonary trunk and pulmonary artery shadow on the superior portion of the left heart border may be found in mitral stenosis, interauricular septal defect, patent ductus arteriosus, pulmonary arteriosclerosis, chronic cor pulmonale and thyrotoxicosis. It may also be present when the left side of the heart has decompensated as in hypertensive heart disease.

Relatively diffuse cardiac enlargement may occur in myxedema, thiamine deficiency, anemia and myocarditis. In myxedema, the cardiac contour may be globular. Pericardial effusion may be manifested by cardiac enlargement to both right and left with fairly convex lower heart borders. Chronic constrictive pericarditis may be suggested by deposits of calcium seen in the cardiac shadow, Distention of the vena cavae may be caused by constrictive pericarditis and may be detected on the routine chest film.

Abnormalities in the thoracic aorta may be found in a survey. Arteriosclerotic or syphilitic aneurysm of the aorta may present a striking X-ray appearance. Lesser degrees of tortuosity and ectasia may commonly be seen in adults of the older age groups. Deposits of calcium may be seen in the aortic knob. Decreased prominence or absence of the aortic knob may suggest coarctation of the aorta. This is especially true if scalloping of the rib margins and left ventricular enlargement are present. Abnormalities in the origin or course of the aortic arch may also be found.

Congenital cardiac lesions may be detected also in a survey. The tetralogy of Fallot may be suggested by the combination of the peculiar boot-shaped heart plus the anemic appearing lungs. Interventricular septal defects may cause enlargement of both the left and the right ventricle. Dextrocardia will be evident by the striking X-ray appearance of the chest. Other congenital cardiac lesions have been mentioned above.

It is essential that those individuals whose routine X-ray films show cardiovascular abnormalities be referred to their physicians for further studies. Only by obtaining a careful history and physical examination and by making judicious use of the electrocardiogram, other forms of radiologic examinations, and other laboratory procedures can an exact diagnosis be arrived at and proper management instituted. It is possible that some completely curable cardiac lesions may be discovered by the survey. The health of other individuals with cardiac disease may be preserved by regulating activity to an optimum level and by applying appropriate therapeutic measures.

The value of a survey to the health of a community is impossible to estimate. It will depend in large measure on how well the physicians of the community perform the task of arriving at an exact diagnosis and advising appropriate therapy.

The Value of Chest X-ray Survey in the Diagnosis of Cardiovascular Disease, George N. Aagaard, M. D., The Journal-Lancet, June, 1947.



WOMAN'S AUXILIARY

SOUTH CAROLINA MEDICAL ASSOCIATION

President: Mrs. D. F. Adcock, Columbia, S. C.

Publicity Secretary: Mrs. Kirby D. Shealy, Columbia, S. C.

TWENTY-FIFTH ANNUAL MEETING

The Twenty-fifth annual meeting of the Woman's Auxiliary to the American Medical Association will be held in Chicago, June 21 to 25, 1948. The head-quarters will be Hotel LaSalle.

quarters will be Hotel LaSalle.

A most cordial invitation is extended to all women, who are Auxiliary members or guests of physicians attending the convention of the American Medical Association, to participate in all social functions and attend the general sessions. Whether Auxiliary members or not, the wives of doctors will be most welcome.

Auxiliary headquarters will be on the mezzanine floor of the Hotel LaSalle. All meetings and functions will be held at the Hotel LaSalle unless otherwise stated in the program, or appropried during the meet-

stated in the program, or announced during the meeting. Please register early and obtain your badge and

program of the social function.

All tickets should be purchased soon after arrival. These will be sold at the Anxiliary headquarters, All meetings and social affairs will begin at the time scheduled. Please be prompt.

REGISTRATION HOURS

Sunday2:00	P.M.	to	4:00	P.M.
Monday9:00	A.M.	to	4:00	P.M.
Tuesday9:00	A.M.	to	4:00	P.M.
Wednesday9:00	A.M.	to	4:00	P.M.

COLUMBIA AUXILIARY HELPS WITH HOUSING STUDY

The Columbia Medical Auxiliary is participating in the 1948 housing study sponsored by the Council for Social Planning. Mrs. Graham Shaw, of the Medical Auxiliary, is general chairman of the study which will include Columbia and the surrounding territories. Mrs. Shaw was appointed to this responsible position by Mr. Ed Conover, local director of the Council for Social Planning.

The Medical Auxiliary is one of several community organizations assisting in the survey to determine health and living standards in residential buildings. Particular emphasis is being placed on obtaining in-formation concerning plumbing, screening, utilities, beating refrigeration rate in the neighborhood, and heating, refrigeration, rats in the neighborhood, and the state of repair of the building. The Auxiliary is surveying a cross-section of the community which should give a broad picture of existing conditions.

The sections to be surveyed by the Auxiliary include in the city, Heathwood, Hampton Terrace, Kilbourne Park; and in the county, Valencia Hills, and the south-end section of Rose Hill. When the survey has been finished, a complete analysis of the statistics will be made to determine the major health and welfare needs of the community. This information will be of great value to all philanthropic organizations in the city.

Approximately fifty ladies of the Auxiliary will participate in the survey. The work is being done by five teams, each team having a captain and ten helpers. The following ladies are serving as captains: Mrs. James T. Green, Mrs. Weston Cook, Mrs. Manly E. Hutchinson, Mrs. Henry Plowden, and Mrs. Gordon

DOCTOR'S DAY

March 30 was widely and variously observed as Doctor's Day by the Auxiliaries in South Carolina. A radio program lead by Mrs. C. P. Corn was the feature of the Greenville observance. The Rock Hill ladies served their husbands a delicious home cooked buffet supper. The Sumter and Anderson Auxiliaries both planned formal dinners and the Anderson doctors were also given red carnations to wear that day. In Columbia the observance took the form of a red rose boutiniere for each member of the Medical Society as well as a timely and appropriate newspaper article. And the doctors of Third District received cards which read, "The Woman's Auxiliary to the Third District Medical Society is very proud of you and your noble work. On this Doctor's Day we wish to pay tribute to you in this simple manner.

COASTAL AUXILIARY

The Woman's Auxiliary to the Coastal Medical Society held its April meeting on the eighth at the Country Club in Walterboro. Members were present from Beaufort, Berkley, Colleton, Dorchester, and Jasper counties. Business included committee reports, the adoption of the constitution, and the election of Mrs. Jack Wertz as delegate to the state convention. Mrs. David F. Adcock of Columbia, president of the Woman's Auxiliary to the South Carolina Medical Association, was the guest speaker. Dinner was served at the conclusion of the meeting.

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MRS. B. S. SMITH ELECTED TO HEAD MEDICAL AUXHLIARY

The Charleston branch of the auxiliary to the South Carolina Medical Association elected Mrs. Bachman S. Smith, Jr., as president at the luncheon meeting of the group. She succeeds Mrs. John Arthur Siegling, Jr.

Other officers elected include Mrs. Clay W. Evatt, vice president; Mrs. Leon Banov, Jr., secretary, and Mrs. Daniel L. Maguire, Jr., treasurer. Mrs. John van de Erve, Jr., was chairman of the nominating committee.

Guest speaker was Mrs. David Adcock, of Columbia, state auxiliary president, who discussed the organization and growth of the auxiliary. She stated that the national auxiliary, organized in 1922 with 65 members, now has a membership of 36,000 which it hopes to double or triple in the next few years.

Main points for the present year are: Increase in the number of branches; increased membership, and assistance in the public relations program. This year the auxiliary's chief project is nurse recruitment. The Charleston branch and one other in South Carolina have given scholarships to deserving students during the year.

In eonclusion, Mrs. Adcock stated that the South Carolina auxiliary now has a monthly bulletin, the first in the country tied in with public relations. The speaker was introduced by Mrs. I. Ripon Wilson, Ir.

The following delegates and alternates were appointed for the Centennial convention of the South Carolina Medical Association, to be held here May 12, 13, and 14: Mrs. Archibald E. Baker, Mrs. Evatt, Mrs. Robert M. Hope and Mrs. Smith, delegates, and Mrs. Matt S. Moore, Mrs. T. Willard Reynolds, Mrs. B. Owens Ravenel and Mrs. William H. Speisegger, alternates.

NEWS ITEMS

Dr. Manley Hutchinson of Columbia was elected President of the South Carolina Obstetrical and Gynecological Society at the second annual meeting of the Society held in Camden on April 3. Dr. W. J. Snyder, Jr. of Sumter was named Vice President and Dr. J. D. Guess of Greenville, Secretary-Treasurer.

Guest speakers at the meeting were Dr. Bayard Carter of Duke University Medical School, Dr. Frank Locke of Bowman-Gray School of Medicine, Dr. L. A. Wilson of the Medical College of South Carolina and Dr. Rowland Zeigler, Jr. of Florence. Dr. J. D. Guess of Greenville was the banquet speaker.

The Mobley-Stokes Eye, Ear, Nose and Throat Clinic (Florence, S. C.) announces the association of Dr. Gordon H. Bobbett, Dr. L. D. Lide, Jr., and Dr. Marion R. Mobley, Jr.

Dr. D. O. Rhame (Clinton) announces the association of Dr. Edgar N. Sullivan in the practice of medicine and surgery.

Miss Electa Hall, daughter of Dr. and Mrs. H. F. Hall of Columbia was named "Miss Columbia" and represented that city at the Peach Festival at Johnston and the Azalea Festival at Charleston.

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The Iournal

of the

South Carolina Medical Association

VOLUME XLIV June, 1948 NUMBER 6

President's Address

OLIN B. CHAMBERLAIN, M. D. Charleston, S. C.

A presidential address by custom, is an attempt to present and comment upon the "state of the Union." Anyone who would set out in the field of medicine to pursue such a course in this the year 1948 would indeed be brave. While it is true that each generation and age regards its particular problems as critical, those of us who are present today are, by common consent, in the most extraordinary age the world has ever known. For the first time in his career, man has produced a Frankenstein capable of instantly destroying the entire race, and leaving this planet bare of human life to begin anew the evolution of a dominant species. The idea is staggering and its implications awe-inspiring. Perhaps the tragic and somber thoughts engendered by the contemplation of our danger will sober us into a realization of the necessity of developing our emotional control as we have developed our intellectual power. The present national news and the prevalent world tension does not as yet give much promise of that happy solution. But we shall continue to hope because otherwise there is little light. Some one has noted that a French diarist of one hundred years ago quotes the scientist Berthelet as making this startling prophecy, "In a hundred years man with his ingenious mind will divide the atom, and shortly thereafter God will come down from Heaven, jingling his keys and saying, "All right, gentlemen, it's just about closing time." Let us fervently trust that the latter part of this prophecy does not prove as accurate as the first.

Our meeting commemorates one hundred years of our organized life. I shall not attempt to summarize the events of those years. Our much esteemed colleague, Joe Waring, who has done yeoman's work in preparation for this celebration, has performed a magnificient service to our Association by writing a history of these one hundred years of progress. You have received or will receive a copy of this accurate and scholarly work.

The problems of 1848 were different from our problems. The practice of medicine was concerned mainly with the relief of symptoms, in pioneer communities. The corner stones of our present science of medicine were virtually unknown. During these past one hundred years were to come the discoveries of cellular pathology, microscopic anatomy and pathology, bio-chemistry and physiology, and, most important of all, bacteriology. This last, combined with anesthesia, gave rise to aseptic surgery, and the ability to explore all parts of the human body with comparative safety. Finally the last few decades have produced discoveries which have led to a knowledge of hormones, with an insight into the nervous and chemical integration of the body. We are now beginning to grasp the concept of the body as a whole, and to understand how, as some one has put it, "fear and resentment can produce ulcers."

Running on parallel tracks, as it were, with this progress in the scientific knowledge of disease, has been the changes of the social aspect of medical practice. Many of us would hesitate to use the word "advances" in this particular aspect of our review.

The doctor of 1848 and his patient were singularly "on their own." Hospitals were unknown, except as poor houses, and pest houses. Clinics, laboratory help, auxillary aids in diagnosis were years in the future. The concept of community, or national responsibility was dim indeed. Boards of health, if existant at all, eonsisted of committees without funds or plans of procedure. There was no state aid, and federal aid was in the dim and distant future. The high cost of medical care had not as yet become a problem. Let us visualize a South Carolina physician of 1848 who confronted a problem in the baffling illness of the daughter of a prosperous planter. Let us say the doctor lived in Darlington. He would very probably have consulted the learned and scholarly Dr. Moultrie, dean of the faculty of medicine at the Medical College of South Carolina. Non-plussed, that gentleman might well have suggested America's current leader in clinical medicine, William Wood Gerhard of Philadelphia. A sea-voyage finally brought our patient to Philadelphia, the center of American Medicine. In a short half hour, this distinguished gentlemen could

have exhausted all modes of inquiry. Besides his own senses, the worthy consultant had one crude help only. He could inspect, and taste, the urine. In 1848, a fee of twenty-five or fifty dollars would be an excellent return for a half-hour's interview with the doctor, whose office consisted of one or two rooms in the ground floor of his brown brick house on Walnut Street. And so the girl from South Carolina would receive all that American Medicine could offer for twenty-five dollars and the expenses of her trip. The cost of treatment was generally in terms of travel. Doctors prescribed balmy climates, and stimulating climates, dry climates and moist climates, in fact any climate which differed from the one in which the doctor resided.

I shall not, in contrast dwell upon the details of the contrasting situation which obtains in 1948. It is however the cost of subsidizing the vast number of auxilliary aids which we have brought to the aids of inspection, percussion, and auscultation which has pyramided the cost of medicine, and made it the important, socio-economic question of the twentieth century.

The vast amount of factual material which has accumulated in the past hundred years has in equal degree changed the practice of medicine. At the turn of the 16th century, Francis Bacon, in the pride of his incomparable 19 year old mind, could say "I have taken all knowledge as my province." In 1848 a young graduate would have considered that the entire range of medical art and science was set before him. The century has brought changes indeed. There are now fifteen boards in American medicine, each setting up standards which require many years of intensive study and training to meet, "General medicine" has itself become a specialty, and we of this association glow with pride when we think that our own beloved Buck Pressley is universally considered to be America's finest example of that most trying of all specialties.

Specialization has, perhaps, been necessary. But it has brought many complications. It is still proceeding. There is a distinguished alumnus of our college and an honorary member of the association who has for many years, in one of America's great clinics, confined himself to a study of the human retina, in health and disease. A colleague remarked that he wondered when Henry was going to announce that from now on he would confine his work to a study of the left retina alone. The two complicating factors of mounting cost and specialization have brought about striking changes in the form of medical practice.

In many parts of the world, Medical practice has been incorporated into state bureaucracy. The mode varies in accord with the social facade of the country. Since in temperament, traditions, and language, England is most nearly like us, we watch with particularly keen interest what is happening there. I am sure I do not have to remind you that under the Labor Government British medicine is undergoing socialization. To

this socialization there is great resistance upon the part of organized British medicine. The British Medical Association, in organization, power and prestige, closely approximates our American Medical Association. It is significant that approximately 84% of British doctors voted, in a recent poll, and 90% of the votes were opposed to the government plan. This, in spite of the fact that the income levels under the bureaucratic plan were quite liberal. It is said that the organizers of the plan deliberately set the financial returns quite high in order to lure medicine into the fold. The fact that British medicine, almost to a man, was against the act, indicated that income was not the reason doctors do not wish to be regimented into a bureaucratic framework.

Rather, to paraphrase the editor of Collier's in a recent thoughtful paragraph, it is the sound conviction of all honest and experienced physicians that medicine in its double aspect as art and science, flourishes best in a free and democratic mode and that the doctor-patient relationship is a real and not sentimental factor which must have primary consideration.

Perhaps the most clinching argument in the whole matter is a modification of the old adage that "the proof of the pudding lies in the eating." Under the ideals inculcated during the past hundred years, American medicine has attained a position without parallel in the history of the world.

The experience of the last two wars, in which a large proportion of American physicians took an active part, served to reinforce the feeling that socialization of medicine brought many evils. It can be said without fear of successful contradiction that where military medicine was good, it was because of the employment of the methods employed in our American civilian medicine, without administrative interference and red tape bungling. On the other hand, when Snafu and inefficiency was present, it could be clearly traced to that same bureaucratic rigidity which we regard with justified suspicion and contempt, and which certain contemplated laws would thrust on us now. No one wishes to return to the primordial situation of 1848. but the vast majority wish to avoid the strangling influence of regimented national socialistic medicine. A few years ago Dr. Bauer put the matter in words with which most of us find ourselves in agreement.

"We advocate continued expansion of the practice of medicine, with full development of approved voluntary hospital, medical, indemnity, industrial and commercial insurance against the cost of medical care; the development of public-health and diagnostic facilities everywhere; the use of the voluntary insurance principle in caring for the medically indigent; the development of hospital facilities where present facilities are used to the utmost and are still inadequate; the use of federal funds to aid communities in public health measures, care of the indigent and construction of necessary hospitals when these communities are unable to finance the projects, but with

retention of local administration. In a word let us move ahead steadily, but carefully, in a sound, evolutionary manner. We must not be stampeded into discarding and destroying what has given an unparalled health record. Let us not forget that private enterprise has made America what it is."

There were many differences between the training, the conditions under which work was carried out, the technical tools, and the social-economics problems of those of us who are in meeting today, and these founding fathers of ours who in 1848 initiated the South Carolina Medical Association. But there were great similarities. Some of the problems are as old as time, and human nature changes little. It may be interesting to glance at some of the proceedings of that founding meeting. I quote from Dr. Waring's book.

"Monday, Feb. 14, 1848.

"Pursuant to circulars issued by the Medical Society (this was the "Medical Society of S. C." founded in 1789 by 10 gentlemen practitioners of medicine in the city prior to the year 1783, who met at the residence of Dr. Peter Fayssoux and unanimously agreed to form a Medical Society), a large number of medical men, from all parts of the state, assembled at 10 o'clock this morning, at the Hall of the Apprentices Library Society.

On motion of Dr. Wragg, the meeting came to order and Dr. James Moultrie was called to the Chair, and Drs. Cain of Charleston and Johnson of Camden, appointed secretaries.

The following gentlemen as officers of the Convention were thereupon unanimously elected,

President

Dr. James Moultrie of Charleston
Vice Presidents

Dr. C. Ready—Edgefield

Dr. Isaac Branch—Abbeville
Secretaries

Dr. D. J. C. Cain—Charleston
Dr. R. Johnson—Camden

The convention then proceeded to pass upon certain resolutions, first resolving itself in a "State Medical Association." Many of these resolutions bring sharply into mind the kinship between ourselves and these doctors of a hundred years ago. I quote from a few:

"Resolved that in our transactions with apothecaries, we will deal exclusively with those who abstain from recommending and vending quack or patented medicine, whenever we have the option."

Here is one, which with a few changes might have been passed this year, since it so closely simulates the activity of our association in State health matters.

"Be it resolved, that the Report on the Registration of Births, Marriages and Deaths, with an accompanying memorial, be presented to the Legislature at its next session, and Resolved that the members of this convention and the members of the Medical profession throughout the State be requested to explain to the Representatives and Senators in their districts, the importance of the measure and use their best exertions

to obtain the passage of the bill."

It was moved that the President be requested to furnish the members of the Convention with certificates of membership to enable them to return on the railroad free of expense. Adopted.

The insistence on good and sound education which organized medicine has always maintained and its support of its colleges is strikingly exemplified in the following preamble and resolution offered by Dr. Dendy:

"However much other causes may tend to embarrass medical reform, we nevertheless regard the failure of Medical Colleges to require a strict conformity, even to their present low standard, as an impediment worthy of the most serious condition. And while it affords us much pleasure to know that the Medical College of South Carolina stands among the first, in her preparatory requirements and in the enforcement of them, we feel that more may yet be done to elevate her still higher.

"It is apparent to all of us that the term of lecturing in all our Medical Colleges is entirely too short to enable the different Professors to do that justice to their subjects which their importance demands, and that it is far too short to enable students profitably to receive the amount of instruction which should be contained in a course of lectures. The door of entrance also into Medical Colleges is not sufficiently guarded.

"The neglect on the part of first course medical students to attend regularly the lectures, is an evil of great magnitude. It is not only an obstacle to the attainment of Medical knowledge, but it tends to consequences far worse—the destruction of morals.

"The examinations for the degree of M. D. are not generally conducted with sufficient care to secure the ends contemplated by their institution. And as this Convention feels the greatest interest in the prosperity and usefulness of the Medical College of South Carolina, and as we look to her as the guardian of the medical profession of this State, and as the institution which is to prepare those to whom are to be entrusted the progress and perpetuity of all reforms in the Medical profession, therefore

"Resolved, that this Convention does earnestly recommend, that the Medical College of South Carolina, lengthen the term of lecturing, from four to six months, that she may better guard the door of entrance and secure the attendance of first course students by examinations; also that she should conduct her examinations for the degree of M. D. more rigidly.

"Resolved, that should she adopt the above recommendations, we will use our influence in her support."

The future is, for reasons foreign to the ideals and hopes of medicine, uncertain. But if we maintain, in our lives and our endeavors, the courage and indomitable spirit of these forefathers, we may see the next one hundred years bring to fruition miracles only dimly visioned now. Let us salute them and seek to emulate their spirit.

A Case of Dysgerminoma with Description of Recurrence

R. B. Durham, M. D.; D. F. Adcock, M. D. and C. A. Sweatman, M. D. Columbia, S. C.

MISS E. L., aged 13, female, single, student. Admitted to the Providence Hospital 2-28-46 at 11:05 A. M.

FAMILY HISTORY: Mother, aged 48, living and well. Father, aged 59, living and well. Brothers 4, living and well. Sisters 4, living and well. Family history negative for T. B. and diabetes. A cousin died of cancer of the lung and her grandmother died of cancer of the stomach.

CHIEF COMPLAINT: Enlargement of lower part of the stomach, and tenderness.

PRESENT ILLNESS: Began two weeks ago, when patient noticed a swelling in the abdomen and complained of the school bus being rough and causing pain in her stomach, and later complained of the car being rough. She had a diarrhea one week before admission to the hospital which lasted three days, but returned to school two days before admission to the hospital. Mother thought patient was dull and had taken less interest in things about the home all Fall and Winter, but showed little, if any, loss of weight and had no nausea and vomiting.

PAST HISTORY: Patient has had the usual childhood diseases. No severe injuries and no previous hospital admissions. Had had earache last December and several times previous to that.

NERVOUS SYSTEM: Essentially negative. No headaches.

GASTRO-INTESTINAL: Negative until present illness.

G. U.: Menstrual periods began August 1945 and lasted eight days. Next menstrual period was January 1946 with normal flow for 7 days. Next period was February 28th and lasted one night. No urinary symptoms.

HABITS: Normal.

PHYSICAL EXAMINATION: Shows a moderately to poorly nourished girl, anemic and apparently acutely ill. HEAD: Normal in contour. EARS; NOSE; and THROAT: Essentially negative. EYES: Pupils round and equal and react to light. CHEST: Expansion free and equal. LUNGS: Clear to percussion and auscultation. HEART: Regular in rate. Apical beat in 5th interspace 3 inches from M. S. L. Blood pressure 125/80. BREASTS: Definitely beginning to develop. Symmetrical and normally prominent for her

age. SKIN: Normal. More hair on upper abdomen than usual in the female of this age. ABDOMEN: Firm, fixed, tumor of lower abdomen extending almost up to the umbilicus and slightly more on the left. EXTREMITIES: Normal. REFLEXES: Normal.

PREOPERATIVE DIAGNOSIS: Tumor mass of lower abdomen, probably ovarian.

LABORATORY: 2-28-46.

BLOOD

Hemoglobin	69%
R. B. C.	2,800,000
W. B. C.	25,000
Polys	76
Lymphocytes	24
Wasserman	negative

URINE

Color	straw
Reaction	acid
Appearance	clear
Sp. Grav.	1.010
Albumin	1 plus
Sugar	negative
Epithelium	1 plus
Pus	few

OPERATION: Midline incision. Marked increase in peritoneal fluid which was bloody. A large ovarian tumor mass was made out which was soft in consistency and appeared hemorrhagic in areas. It filled the entire pelvis and was adherent in some areas by small recent adhesions.

The right ovary was removed and the right broad ligament ligated with No. 2 chromic catgut. Sulfathiazole was placed in the wound, one cigarette drain and closure of wound in layers.

The patient received three transfusions; 2-28-46: 3-1-46: and 3-2-46.

PATHOLOGICAL EXAMINATION: 2-29-46 Preoperative diagnosis: Tumor of the abdomen, type undetermined. Nature of operation: Right Oophorectomy. Material for examination: Right ovary.

GROSS DESCRIPTION: Specimen consists of a large tumor measuring 15x13x11 cm. It is covered by intact peritoneum except at one end where it has been torn. Externally it feels soft and cystic. However, on section, it is found to be made up of soft, yellowish-white translucent tissue with considerable areas of



MICROSCOPIC PICTURE OF SLIDE OF DYSGERMINOMA

hemorrhage. At one pole there is similar tissuc which, however, appears firmer grossly.

MICROSCOPIC: The tumor is made up of generally large masses of tumor cells with a small amount of fibrous stroma. There are large areas of necrosis and hemorrhage. The tumor cells are moderately large and ploygonal, cytoplasm and granular. The nuclei are hyperchromatic. Mitosis is frequent.

DIAGNOSIS: Dysgerminoma of the ovary.

(Signed) R. Barnett, M. D. Pathologist

Due to the condition of the patient at the time of the first operation the appendix was not removed. Saturday, May 11th, she developed a generalized abdominal pain followed by localization in the right side and an acute appendix was removed. Following the operation, however, she became distended, vomited and seemed to be developing a paralytic ilieus. This may have been due simply to her poor general condition as she later improved and left the hospital apparently well.

SUMMARY: A case of dysgerminoma has been reported in a young girl with a large solid tumor, showing multiple areas of hemorrhage and necrosis. She has apparently normal secondary sex characteristics and no abnormality. Thus far no distant metastusis, nor recurrence of the tumor has been noted.

RECURRENT DYSGERMINOMA

This patient, MISS E. L., aged 15, female, single, student, was admitted to the Baptist Hospital II-17-47 at 4:00 P. M.

CHIEF COMPLAINT: Lump in right side. First noticed week ago. Soreness.

PRESENT ILLNESS: First noticed lump about week ago. Has grown since first noticed. Last mensural period October 28, 1947.

G. U.: Menstrual periods began August 1945 and lasted 8 days. Last menstrual period October 28, 1947. No urinary symptoms.

HABITS: Normal.

PHYSICAL EXAMINATION: Abdomen: Sears in lower mid-line and R. L. Q. Large, irregular, tender mass in lower abdomen—more on right than left.

PREOPERATIVE DIAGNOSIS: Recurrent dysgerminoma of left ovary.

LABORATORY: 11-17-47.

BLOOD

Leukocytes	9,300
Polynuclear neutrophiles	58
Polynuclear eosinophiles	0
Polynue!ear basophiles	0
Lymphocytes	42
Mononuclears	0
Transitionals	0
Myelocytes	0
Hemoglobin 11-26-47	91

URINE

Albumin	0
Sugar	0
Pus	oeeasional
Casts, blood, crystals, amorphous	0

OPERATION: Left oophorectomy, biopsy of tumor mass mesentery of sigmoid, separation of bladder adhesions.

Enlarged tumor of left ovary which was multiloculated. A multi-loculated tumor of left ovary approximately size of a large grapefruit. The ovary was semi-solid giving the appearance of ground beef with no evidence of hemorrhage into the tumor mass. However, the tumor mass was apparently breaking down. There was a cystic area at the upper pole of this ovary approximately the size of a lemon which contained a straw colored fluid. There was a mass in the mesentery of the sigmoid colon approximately the size of a lemon which was soft and fluctuate and contained a creamy substance which was apparently pus without odor. There was several adhesions between small intestine from previous operation which were separated and ligated; however, there was no apparent interference with the function of the intestine. The old midline scar was removed. The pediele was doubly ligated with No. 2 chromic eatgut. Hemata stasis was controlled at the sight of separation of the ovary deep in the cul de sac with a running suture of plain catgut. This bleeding was mainly over the right uterosacral ligament. Three sections were taken from the mass in the mesentery of the sigmoid to rule out the possibility of metastasis. Five grams of sulfathiazole crystals were placed in the area. Peritoneum closed with plain eatgut continuosuly. Muscles closed with plain eatgut continuously, Tension sutures of silk worm gut were placed beneath fascia. The fascia was closed with

interrupted stainless steel sutures. Skin was closed with silk worm gut and approximated with skin clips. One cigarette drain.

PATHOLOGICAL DIACNOSIS: 11-29-47 Specimen received: Left ovary, tumor mass of left ovary, following removal.

A torn fairly solid ovarian mass measuring 13 cm. in diameter and having fallopian tube attached. On section it is greyish pink and quite resilient.

Sections of ovary show a highly anaplastic growth of ovoid cells supported by fibrous stroma righ in lymphocytes and typical of dysgerminoma. Section of fallopian tube shows serosal implants of the same type growth. DIAGNOSIS: Dysgerminoma of ovary with peritoneal extension.

(Signed) Kenneth M. Lynch, M. D. per; W. M. Cannon, M. D.

This patient was dismissed from the Baptist Hospital 11-3-47 at 11:10 A. M. and has been receiving deep x-ray therapy for the metastatic nodule in the mesentery of the sigmoid. This nodule cannot now be palpated.

RECURRENT SUMMARY: A dysgerminoma arises from the neutral cells of the ovary, and according to Novak, are less malignant than the granulosa cell cancers, but more malignant than the arrhenoblastomas. A similar tumor of the testis is known as a seminoma, and occasionally the dysgerminoma is called a seminoma of the ovary. The seminoma, in contra-distinction to the dysgerminoma is highly malignant. In Seegar's review of 79 cases in 1938, 48% were on the right ovary and 26% were bilateral. The right ovary shows more development abnormalities than the left, which may explain the tendency of this tumor to be located on the right side.

It is of a low grade malignancy from a clinical standpoint, but very malignant in appearance on the slide and macroscopically. It is approximately of brain consistency and has an extremely rapid growth. However, the two weeks history obtained in the first hospital admission on this particular case was probably due to hemorrhage and pecrosis of the tumor mass. This also explains the temperature, malaise, nausea, voniting and shock. This tumor is frequently associated with arrested sex development and is usually

found in young women. Pregnancies have been reported after removal of dysgerminomas. This is reasonable in a neutral tumor, as one of us, Dr. C. A. Sweatman, has had a pregnancy occurring after the removal of an arrhenoblastoma in a very masculine appearing female.

This case showed remarkable radio sensitivity, and this agrees with most authorities on the subject. In Seegar's original review of the literature no case was found in which there was a metastasis to the lung.

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January.

Peptic Ulcer of the Esophagus

Report of a Case

Gertrude R. Holmes, M. D. Greenville, South Carolina

Case Report:

A. G., a white male, age 54, of Greer, South Carolina was seen on October 5, 1943 complaining of pain in the abdomen and vomiting. Pain in the abdomen began in 1937 and a diagnosis of duodenal uleer was made. Pain would recur periodically and be accompanied by considerable heart burn and eructations. Symptoms had been constant since May, 1943. Since then he had remained on a rigid diet of milk, eggs and strained oat meal and had lost about twenty pounds in weight. For the past forty-eight to seventy-two hours he had been vomiting.

Past history revealed that he had lost his right arm at the age of 12 in an accident in a cotton gin.

Appendectomy was performed in 1937.

On physical examination he was malnourished, weighing 115 pounds. Height was 68¼ inches. The right arm had been amputated just below the shoulder. There was marked dental sepsis. Radial arteries were thickened and there were varicose veins of the lower extremities.

The patient had a large gastric residue which contained free hydrochloric acid 62 degrees and total acidity 100 degrees. A gastric lavage was done and following this a barium meal was given. The stomach was dilated and there was complete pyloric obstruction.

The patient was admitted to St. Francis Hospital to be prepared for surgery. He was scheduled for operation on October 9th and when seen just prior to operation he stated that during the night he had experienced sudden severe abdominal pain. He had board-like rigidity of the abdomen. On opening the abdomen a perforated duodenal ulcer was found. Under the circumstances it was impossible to do anything more than close the perforation. Postoperatively he got along well and was discharged on November 1st on a modified Sippy diet, antispasmodics and alkalies.

He remained well until about the first of December, 1947 when he began having abdominal pain occurring one to one and a half hours after meals with a good deal of eructation. An x-ray was done on December 30th, 1947. The esophagus and stomach were negative and the stomach was practically empty in two hours. The duodenum was narrowed from the previous operation but no evidence of an ulcer was seen. Patient was put on a strict ulcer regime. Three weeks later he began to complain of pain in the right upper

quadrant and almost constant nausea. There was vomiting on only one occasion. On the night of January 26, 1948 he was admitted to the Greenville General Hospital. On physical examination the only finding of significance was that of tenderness to the right of the umbilicus. Heart and lungs were normal. Blood pressure 145/80. He had a large incisional hernia. He was given intravenous fluids and a Sippy diet when tolerated.

On January 29th an x-ray of the gastro-intestinal tract was done. The report follows:

"Fluoroscopy of the chest shows no abnormality of heart or lungs. The barium water mixture was swallowed without difficulty and outlined a normally appearing esophagus. The stomach was extremely large and contained a large non-opaque residue. None of the opaque material was seen to leave the stomach and a film exposed five hours after ingestion of the meal showed almost all of it remaining in the stomach. A lateral film showed some barium in a deformed duodenal bulb."

After the five hour film the patient was returned to the ward. Immediately afterwards he vomited and following this he had severe epigastric pain which he described as similar to the pain of the previous perforation but much worse. On examination shortly after this episode the patient was in mild shock and the abdomen was board-like. Blood pressure 110/80. Temperature rose to 102 degrees. White blood count was 17,150. Polys were 89% and lymphs 11%. A film exposed in the upright position showed no free air in the peritoneal cavity.

Surgical consultation was immediately obtained and within two hours the patient was operated upon under spinal anesthesia. There was complete pyloric obstruction and much scarring of the duodenum but no evidence of a recent perforation. Conservative surgery was indicated on account of the patient's condition so a posterior gastrojejunostomy was performed to relieve the obstruction and patient left the operating room in good condition. Postoperatively he received two blood transfusions and Streptomycin, and Wangensteen suction was instituted.

Twenty-four hours later he complained of pain in the left ehest which was aggravated by breathing. On examination the left thorax was almost immobile and there was dulness and bronchial breathing over the base. It was felt that he had either Pneumonia or Atalectasis of the left lower lobe. Temperature was 100.4. He was started on Penicillin and Streptomycin was continued. The following day he became worse and temperature rose to 105. He was put in an oxygen tent and improvement was noted. A portable x-ray of the chest was done which revealed a large effusion in the left pleural space. The following morning, February 1st, he became worse. Aspiration of the left pleural cavity was performed and about 1000 cc of turbid brownish vellow fluid with a fecal odor was removed. During aspiration the patient expired.

An autopsy was performed and the report follows:

"In the thorax the right lung is free with approximately 400 cc of almost clear fluid. The left lung is very much compressed both anteriorly and posteriorly by large areas of fresh empyema although the fluid is brown and not yet frank pus. A heavy coat of fibrinopurulent exudate is present over the pleural surface. The left lung is almost completely atalectatic and the bronchial tree shows a moderate amount of mucopurulent material. The esophagus, stomach and duodenum were removed intact. There was a 1 cm, ragged perforation of the lower end of the esophagus. On opening the esophagus several small superficial ulcerations were seen but surrounding the perforation was a round ulcer with a necrotic base 2 cm, in diameter. This had ruptured into the posterior mediastinum and extended into the pleural space giving rise to the empyema previously mentioned. There was another fairly deep ulcer 2½ x 1 cm, at the same level (immediately above the gastro-esophageal junction) which had not perforated. The stomach was dilated and the operative stoma was perfectly intact. The pylorus was completely obstructed from an old ulcer on the anterior wall. In addition there was a 1 cm, deep fresh duodenal ulcer on the posterior wall which had penetrated to the serosa and was closely attached to the pancreas. A few small areas of fat necrosis were present,"

Discussion:

Peptic ulcer of the esophagus is not so rare a condition as was previously thought. This is particularly true since the advent of esophagoscopy. Jackson (1) in 1929 reported twenty-one active and sixty-seven healed ulcers in four thousand esophagoscopic examinations on patients suspected of having esophageal disease. Friedenwald, Feldman and Zinn (2) reported thirteen cases in which the diagnosis was made by roentgen examination. Often, however, the lesion is missed. Jackson describes the ulcer as being "flat" and offers this as one explanation of the failure to demonstrate it by roentgen examination particularly in the early stages. Later when cicatricial tissue forms stenosis may be demonstrated. Certain conditions are necessary for the production of peptic ulcer of the esophagus, either the presence of aberrant gastric mucosa or patency of the cardia through which there is a retrograde flow of gastric juice. Chamberlain (3) of the Lahey Clinic in 1938 suggested an abnormality which might be responsible for patency of the cardia and reported seven cases, six of which had either a

congenitally short csophagus, a diaphragmatic hernia or both, and the seventh having aberrant gastric mucosa.

Peptic ulcer of the esophagus occurs predominantly in the 4th and 5th decades and with equal incidence in male and female. It not infrequently occurs concomitantly with ulcer of the stomach or duodenum.

Symptomatology: The lesion may be symptomless or symptoms may be vague resembling a functional disorder and are too often attributed to psychoneurosis (4). Pain is usually retrosternal and extends through to the back. It occurs earlier after meals than that of ulcer of the stomach or duodenum. It is invariably relieved by alkalies. It may occur after solid food but not after liquids. Heart burn and vomiting are usually present. Dysphagia occurs late. Hematemesis and melana may occur. Diagnosis is made by: 1. Esophagoscopy with biopsy of the lesion: 2. Radiography and: 3. Autopsy.

Treatment: 1. That of peptic ulcer in general; 2. Jackson applied 10% silver nitrate directly to the ulcer; 3. Hurst recommends temporary gastrostomy in all cases. Others feel that it should be used only after a medical ulcer regime has failed.

Complications: 1. Hemorrhage: 2. Obstruction and 3. Perforation. Fatal hemorrhage is rare (5), Obstruction may be relieved by peroral dilations. If this cannot be accomplished, gastrostomy is necessary and retrograde dilation is done.

Until recent years, perforation resulted in high mortality. Ralph Adams (Lahey Clinic) (6) reports that after the adoption in 1943 of a plan consisting of immediate gastrostomy, extra pleural mediastinotomy, and massive chemotherapy seven patients were treated by this method, with recovery. If perforation is suspected fluoroscopic and roentgenologic examination with barium is immediately done. If there is extravasation of barium immediate surgical drainage is instituted. In addition a gastrostomy is done for purposes of fluid and food administration and to allow the esophageal perforation to heal. High blood levels of Sulfadiazine and Penicillin are maintained until all systemic signs of infection have subsided.

Conclusion:

A case of a fifty-nine year old man with multiple peptic ulcers of the esophagus is reported. There was perforation of one of the ulcers with resulting mediastinal empyema, empyema of the left pleural cavity and death. There was present also the scar of an old perforated anterior wall duodenal ulcer and a fresh penetrating ulcer of the posterior duodenum. There was complete pyloric obstruction. In this patient, theoretically at least, one of the conditions necessary for the development of peptic ulcer of the esophagus was fulfilled, i. e. the presence of marked gastric stasis with a greatly dilated stomach allowing retrograde flow of gastric juice. Unfortunately microscopic

examination of the esophageal ulcers for the presence of ectopic gastric mucosa was not carried out because of the resignation of the pathologist.

The symptoms of ulcer of the esophagus were masked by the symptoms referable to the acute duodenal ulcer and its accompanying pyloric obstruction. This is easily understood when it is recalled that the segmental localization of pain in lesions just above the cardia is almost the same as that of duodenal ulcer. In retrospect, when no perforation of any abdominal viscus was found to explain the patient's episode of acute pain with shock and a board-like abdomen, an intrathoracic surgical emergency should have been suspected and proper treatment instituted. In retrospect also, it is interesting to speculate that if there had been sufficient time to relieve the gastric stasis surgically before perforation took place, the esophageal ulcers would then have had an opportunity to heal spontaneously.

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Public Health and Protein Nutrition

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Protein, iron, and vitamin deficiencies were reported in 20% of a South Carolina Medical patient survey during 1946.¹ State Board of Health reports for 1945-46 in South Carolina show nutritional defects in approximately 10% of well-baby clinic patients.² Nutritional deficiencies are widespread among adults and school children in the United States.³

Malnutrition exists in every country in the world. Lack of medically complete surveys handicap the formation of a program for study. Therefore, discussion is here limited to the protein content of example South Carolina diets.

A decline in incidence of the avitaminoses is ascribed to the attention given to their clinical states during the past several years. But little attention has been directed toward the equally vital malnutritive states involving protein intake, nitrogen balance, and amino acid content of dietary protein. Attention is herein to be focused on calculations of the amino acid content of various example diets in South Carolina.4

The biological function of protein is well known. In furnishing nitrogen to body tissues, many proteins also furnish a source of phosphorus, sulphur, minerals, and vitamins as a prosthetic. A most important observation concerning the variety of proteins is the varied amino acid content, and it is the effect of the latter with which investigators are now primarily concerned. Progress toward information that may cause much change in dictary habits, and dictary recommendations of physicians is rapid. There are undoubtedly other nitrogenous compounds about which little is as yet known.

Proteins and their constituent amino acids are important in any nutrition program. Essential amino acids are required by animals since their individual cells do not form specialized molecules without certain of these amino acids known to be indispensable. Blood plasma and liver storage fractions are thought to be readily broken down to supply nitrogen for other purposes, but when these stores are depleted, the remaining tissue proteins are retained. Many workers have made dietary deficiency surveys. The reports by Price¹ and the South Carolina State Board of Health² are examples. Youman⁵ found hypoproteinemia present among mountain people in Tennessee to be 20%. Such results are questionable, inasmuch as these states are usually associated with other physical abnormalities.

Adequate quantities of protein are required, and must contain minimal percentages of all the essential amino acids. These essential acids cannot be synthesized by the body. 8 of them have been found out of the 22 known amino acids to be indispensable to body metabolism. They are: Isoleucine, Leucine, Lysine, Methionine, Phenylalanine, Threonine, Tryptophane, and Valine. Hence, standardization of protein and amino acid content is primary.

The status of the specific amino acids in relation to human health and disease is yet in the experimental state. Information is not fully available concerning specific symptomatology of individual amino acid deficiencies. While this is so, medicine cannot properly ignore the signs of the future, and any work that will contribute to a more complete knowledge of the processes of health and disease will benefit every other branch of medicine.

Other dietary factors have not been herein overlooked. It is established that the requirements of a complete qualitative diet as we know it today must contain adequate amounts of the following:

- 1. 8 essential amino acids derived from proteins.
 - 2. An adequate caloric intake derived from carbohydrates, or fats and protein sources in part.
- 3. 3 essential fatty acids.
- 4. 13 different minerals.
- 5. 13 distinctly separate vitamin factors.

Quantitative factors are determined by individual needs and states. Many persons obtain adequate amounts by increasing intake enough to provide a high safety factor when supply permits. Proper dietary requirements can and must be met at an economic level low enough to provide adequate nutrition for the populations of the world.

Proteins will be herein considered from a standpoint of: (1) Calculations of amino acid content of human dietary protein, with several exemplary South Carolina diets. (2) Evaluation of amino acid content of dietary protein. (3) Utilization of protein intake by man.

CALCULATIONS OF EXAMPLE SOUTH CAROLINA DIETS

Amino acid analyses

The requirements of Macy, from Block and Bolling,6 are compared to amino acid content of diets shown in graphic form. They are arbitrarily accepted for comparison.

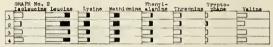
In graph #1 the source material diets4 show marked deficiencies on the Macy scale. Diets 4, 5, 9, and 10, are adequate in all essential amino acids compared to the recommended Macy amounts. Actual amino acid content is shown in blocked areas, and deficiencies in black. Diets 3 and 8 are adequate in some amino acids, whereas 1, 2, 6, and 7 show scriously lowered daily amounts of all essentials.

In computing amounts indicated by graphs, actual dietary elements were evaluated for protein content, and calculations carried on by use of a table prepared from Block and Bolling.6

GRAPH No. 1	cine Lysine	Wethioning #	henyl-	TEXELS-	Valine
1				<u> </u>	
2			1		
3				þ	
4				Þ	
5				Þ	
6)	
7]	þ	
B 🗀				þ	
9				þ	
10				þ	
Graph of 10 ex 1 - 5 white.	emplary S. C.		Legend	1 em • 5 gm	A. A.

Graph No. 1:

In contrast to the Coastal farm diets, average diets in the Piedmont and Coastal sections of South Carolina show consistent deficiencies. It is to be expected that low content diets would average the higher ones at such amounts. Analyses are shown in Graph 2.



Oraph of average dieta of 2 S. C. sections: (4) Legend: 1 cm = 5 gms A. A. 1 - 2 low Piedmont & Coastal. 3 - 4 average Piedmont & Coastal.

Graph No. 2:

In the school lunch studies⁴ it was impossible to calculate the total protein intake per day. Amino acid content was determined from data furnished on lunch served at the "complete lunch school," and this multiplied by 3. Average daily intake thus had is probably higher than actual intake. In any event, 3 such meals would not have provided recommended daily amounts of all 8 essential amino acids.

Graph No. 3:

No data was available for "partial lunch" calculation. Apparently it was lower than the "complete lunch", which would place these children on an even lower amino acid intake.

There is no doubt that the school lunch is of much value to growth and attitude of the child. From these calculations it appears that fortification would insure an adequate amino acid intake, especially in view of dietary control afforded at public schools. Evidence of beneficial effects of school lunches is shown in the following example.4

"One girl of 14 years, weight 63-1/3 lbs. at the beginning of the school lunch study, already retarded 4.9 years by the Wetzel Grid comparison—but of short height and with a normal ht./wt. ratio, finished the study with a weight gain of 15 lbs., and increased height of 3.8 inches. This child showed definite improvement in the complete lunch group, but was still below the 98% auxodrome line."

Hemoglobin studies were conducted in both of these schools. Those of the complete lunch group remained at levels found when the study began. Those of the partial lunch group completed the study program with definitely lowered Hb levels. This is in accordance with theories of Hb formation through exogenous adequate protein intake of complete biologic value. Additional surveys indicate that average South Carolina children are below American averages of Height, Weight, and Hb levels.

Whether or not the subjects of the farm diet survey showed signs of malnutrition is doubtful, principally because of possible complications. These subjects are in a good position to grow most of their foodstuffs. From the graphs of amino acid content in their diets, it is evident that they do not consume enough of their best protein source foods.

Protein Requirements

Terroine's 7 standard indicates that about 18.75 gms. per day of average animal protein will replace the nitrogen expenditure of about 3 gms. per day. Whereas, Sherman 8 predicates a requirement of protein intake of 21 to 65 gms. per day, averaging 44.4 gms., day for a 70 Kg. adult. Growing children's requirements are variable, in the neighborhood of 3.0 to 4.5 gms./kg./day, or 1.5 gms./lb./day.

Some authorities accept the daily allowance of 1 gm./lb./day, or 70 gm./day for an average adult. Leitch9 estimates the normal average amount to be 80 gms./day for a 50% margin of safety, based on animal experiments. McCollum10 places the adult daily allowance of protein at approximately 110-120 gms./day.

There is no evidence of deleterious effects from extreme intakes of protein, if essential amino acids and supportive elements are adequate. For tissue restoration after wasting disease or trauma, animal protein is held to be superior to vegetable protein, due to the high essential amino acid content of the former. In order to compare so-called balanced diets, there follows three sample diets containing 50, 70, and 100 gms. protein per day, using moderate amounts of complete proteins. The accompanying graphs indicate the apparent inadequacy of the 50 and 70 gm. diets in essential amino acids.

DIET NO. 1:

1	Pint of Milk or Milk Equivalent15 Gm.	Protein
1	Egg6 Gm.	${\bf Protein}$
2	Oz. Meat, Poultry, or Fish12 Gm.	${\bf Protein}$
3	Avg. Servings of Vegetables 3 Gm.	Protein
2	Servings of Fruit 2 Gm.	Protein
4	Slices Bread or Equivalent	
	Grain Product12 Gm.	Protein

TOTAL Protein 50 Gms. Protein

DIET NO. 2:

16	oz. Fluid Milk or Milk	
	Equivalent15 Gm.	Protein
3	Oz. Meat, Poultry, or Fish18 Gm.	Protein
1	Oz. Ameirean Cheddar Cheese 6 Gm.	Protein
3	Oz. Cooked Legumes 6 Gm.	Protein
3	Oz. Potatoes, Irish or Sweet 2 Gm.	Protein
3	Servings Vegetables, 1 Leafy	
	Green 3 Gm.	Protein
2	Servings Fruit, Citrus or Tomato 2 Gm.	Protein
6	Slices Bread or Equivalent	
	Grain Product18 Gm.	Protein

TOTAL Protein 70 Gms. Protein



Graph No. 4-A.



Graph No. 4-B.

DIET NO. 3:

40	Oz. Fluid Milk or Milk	
	Equivalent46 Gm.	Protein
2	Eggs12 Gm,	Protein
3	Oz. Meat, Poultry, or Fish18 Gm.	Protein
1	Oz. American Cheddar Cheese 6 Gm.	Protein
3	Oz. Cooked Legumes 6 Gm.	Protein
1	Serving Potatoes, Irish, or Sweet 2 Gm.	Protein
3	Avg. Servings Vegetables, I Leafy	
	Green 3 Gm,	Protein
2	Servings Fruit, Citrus or Tomato 2 Gm.	Protein
5	Slices Bread or Equivalent	
	Grain Product15 Gm.	Protein
	TOTAL Protein 100 Gms.	Protein

ORAPH No. 4-0 Isoleucine Leucine	Lysine Methioni	Phonyl-	Threonine	Trypto-	Valine
1]	
Oraph of 100 gm pro	tein/day diet.		Legend: 1 c	m a 5 gm+	A. A.

Graph No. 4-C:

Graphs Nos. 4-A-B-C show that the 100 Gm./Day Diet is the most complete, with the 70 Gm./Day diet Deficient only in Mcthionine. Obviously the 50 Gm./Day Diet is borderline.

Commercial preparations of palatable and compatible oral and parenteral amino acid mixtures are available from several sources at present as dietary supplements. An example of each type is hereunder graphed for comparisons.



Graph No. 5:

Prophylaxis may be employed to circumvent amino acid deficiencies. The Food and Nutrition Board of the National Research Council recommends the daily allowances of protein and calories for normal individuals as hereinafter tabled:

		Total
Subject	Protein	Calories
Man-70 Kg.	70 Gm. (1 Gm. Kg.	2500-4500
· ·	Body Wt.)	
Woman-56 Kg.	60 Gm. (I Gm. Kg.	2100-3000
9	Approx.)	
Pregnancy, last ½	85 Gnr. (Approx. 1.5	2500
.,	Gm. Per 2500 Gm.	
	Normal Wt.)	
Lactation	100 Gm. (Approx.	3000
	1.7 Gm. Per	
	3000 Gm. Normal	
	Wt)	

	77 (1)			
CHILDREN:	Protein	Total		
Under I year	3-4 Gm. Gm.	100 Kg.		
1-3 Years	40 Gnis.	1200		
4-6 Years	50 Gms.	1600		
7-9 Years	60 Gnis.	2000		
10-12 Years	70 Gnis.	2500		
Girls: 13-15 Yrs.	80 Gms.	2800		
16-20 Yrs.	75 Gnis,	2400		
Boys: 13-15 Yrs.	85 Gins.	3200		
16-20 Yrs.	100 Gms.	3800		

Predicated protein requirements on provision that total caloric requirements are supplied without drawing on protein supply for fuel.

EVALUATION OF DIETARY PROTEIN

Because protein for tissue building is a known requisite of animals, a study of the amino acid content of proteins is of value, with special regard for those 8 essential amino acids already listed. All proteins do not contain such acids in sufficient quantities to meet body requirements. Evidence points to endogenous synthesis of the 14 other known amino acids when not present in the diet. It appears—however, that lysine might not be actually essential, possibly being anabolized through methionine as an intermediate product.

Limited growth, diminished vigor, impaired fertility, and lowered antibody mannfacture are manifestations of inadequate complete protein intake, or utilization. These symptoms of malnutrition are a part of the picture of an impaired or improper growth. Edema from hypoproteinemia is a practically unknown single symptom, and is rarely if ever—seen alone. It is seen in various malnutritive states, which have been called "famine edema." "prison dropsy." "hunger swelling," and other names.

Amino Acid Content of Proteins

Quality of protein amino acid content is indicated by the "biologic" value factor. It is defined as the % of absorbed nitrogen, (N intake minus fecal N of dietary origin) not eliminated in the urine in the course of normal metabolic processes with all dietary elements properly adjusted. It is an index of the ability of proteins to fulfill growth and maintenance requirements of an organism. For instance, the biologic value

of gelatin is "0" when considered as a sole source of protein, whereas that of milk is 85% when considered in like manner. Hence the biologic values of protein appear to vary largely in accordance with their amino acid content. Animal and fish lean meat, eggs, milk, being rich in essential amino acids, are of high "biologic value."

The coefficient of digestibility of meats is high, yielding 95-100% of their nutritive value, while that of legimes and tubers is about 80%. Plant proteins yield small amounts of the essential amino acids. Animal proteins then appear to be the ideal amino acid source.

The quality of proteins supplied is related to conditions of animal growth, maintenance, reproduction, tissue repair, lactation, probably disease resistance, and antibody formation. If energy be not supplied by endogenous carbohydrate and fat, then it must be derived from protein sources, of which up to 60% will be used as fuel alone when not supplemented. Experiments have indicated that dietary amino acid content available for body use in tissue building, repair, or replacement, will not be sufficient if caloric fuel requirements so reduce the anabolic residue of protein that the above functions be not properly served. Some conditions require more proteins solely in order to obtain vital necessities in the absence of other sources. Hence, it may appear that more protein is required than is actually needed.

Growth and Maintenance

The role of proteins in growth, development, repair, and antibody titre in immunization against specific diseases is vital. Extent to which proteins affect these factors has recently been fully recognized. Animal studies indicate that such data is applicable to man. Protein's role in building tissues, plasma balance, osmotic pressure, enzyunes, hormoues, and antibodies is equally vital.

For instance, Madden 11 has shown that plasma protein is not static; it reflects the tissue stores, and there is a ready interchange between plasma proteins and Hb, termed "dynamic equilibrium." In this fashion, a protein pool of the body furnishes materials when needed for whatever emergency.

When protein starvation occurs, plasma proteins are

the first drawn upon for metabolic needs. Not all dietary proteins are of equal value as precursors of plasma protein. Fresh and dried beef serum is acknowledged to be of highest potency for plasma production. Egg white, beef muscle, liver, casein, and gelatin, follow in order. For Hb production, plasma, Hb itself, casein, beef serum, and amino acid mixtures have proven best.

When Rose, W. C.12 fed the 8 essential amino acids to healthy young men they remained in N balance with adequate supplements of other dietary factors. Furthermore, a deficit of any ONE of these 8 amino acids caused N. imbalance.

Tissue injury, whether from trauma, burns, infection, or major surgery, is associated with N losses, possibly quite large. A negative N balance occurs. In fractures an initial average weight loss of N has been observed to be as high as 220 gms. within 24 hours after injury13. Increased high quality protein and caloric foods do not halt the initial destruction, as in starvation per se. There can be found no plausible explanation for this process. Plasma and protein losses in burns and infections are proportionately high, as much as 50 gms. protein/day. No attempt to replace such losses may lead to delayed wound healing, edema, gastro-intestinal function impairment, peptic ulcers, and liver damage.

Children are usually found in positive N balance during the most active periods of their growth, with some recession between the ages of approximately 4-5 and 12-13 years. After reaching 20-23 years of age they will show a neutral N balance if licalthy and if adequately supplied with dietary proteins. It is evident that the biologic value of protein is most important during the growth years, and important also for proper maintenance as an adult.

Liver damage, whether from infection, poisoning, trauma, or idiopathic cause, has been found to respond to high protein intake of proper amino acid content, plus high "B-complex" vitamin supplement. Prior intake is undoubtedly also a factor.

Whether amino acid dietary content is a factor in carcinogenesis is yet to be fully determined.

UTILIZATION OF DIETARY PROTEINS

Tissue Formation

Comparatively little is known about body processes in which N forms body proteins. Amino acid concentrations rise in the portal venous blood after ingestion, and subsequently soon return to normal values. Amino acid concentration in tissue is about 10 times that in plasma, suggesting that syntheses of tissue occur at the site of cells themselves. It is likewise evident that selection of required amino acids is made by the cells.

Concentration of plasma, albumin, and globulin in

the blood is a major factor in fluid balance. Since one gram of albumin will exert approximately 3 times the osmotic pressure of one gram of globulin, it follows that total pressure is not necessarily proportional to total protein concentration in the blood.

Plasma protein colloids act as carriers in the transportation of various substances, either by absorption or chemical combination.

Causes of decreased body protein are faulty or inadequate intake, insufficient utilization, or excessive loss. Assuming the liver to be the focal point of protein regeneration, 14 deficiencies may be classified as prehepatic, hepatic, and post-hepatic. Lowered dietary intake, defective digestion, absorption, and abnormal action in the G-I tract may be classified as pre-hepatic. Liver function impairment will result directly in respect to plasma formation. Post-hepatic decrease may be any cause for excessive demand, or excessive loss, as in injuries, burns, or surgery.

Principal factors then may be classified:

- 1. Inadequate intake.
 - A. Anorexia, nausea and vomiting due to gastrointestinal disorders, congestive failure, pregnancy, or infectious disease.
 - B. Self imposed or therapeutic restriction; psychoneurosis, chronic alcoholism, fads, ignorance, poverty, or supply.
 - C. Improper cooking and processing.
- 2. Poor absorption.
 - A. Gastro-intestinal disease, loss of mucosal integrity, hypermotility, fistulas, obstructive jaundice, and Wangensteen suction.
 - B. Protein deficiency per se.
- 3. Decreased utilization.
 - A. Hepatic disease.
 - B. Malignant disorders.
- 4. Increased excretion.
 - A. Lactation.
 - B. Parenteral fluids.
- Destruction.
 - A. Alkalis, sulfonamide compounds, arsenicals.
- 6. Increased requirements.
 - A. Fever, infection, pregnancy, trauma, burns, ulcers, nephritis.
 - B. Metabolic disorders, diabetes, hyperthyroid-
 - C. Activity, growth, blood donations.

Physiologically: Protein deficiencies may produce:

- 1. Lessened blood volume.
- 2. Increased interstitial fluid volume.
- 3. Retardation of wound healing.
- 4. Lowered resistance to infection.
 - A. Perhaps due to depletion of essential protein matrix of body cells, impaired antibody (gamma globulin) formation, altered water balance, or a combination of all three. Precise mechanism unknown.
- 5. Decreased resistance to intoxications,

- Muscular atrophy and emaciation in extreme states, with edema.
- 7. Abnormal fatiguability,
- 8. Limited and retarded growth of children.
- 9. Psychosomatic manifestations of malnutritive natures.

Breakdown of protein into constituent amino acids occurs in the digestive process. In eases of impaired digestion, the supply of amino acids fails to reach the tissue cells, and catabolism with atrophy occurs. Exactly where N reserves, if they exist as such, are stored in the body is unknown—in spite of the theory of blood plasma as a reserve supply. When intake exceeds requirements excess is excreted in the urine Children need high protein intake, and consistently show a positive nitrogen balance when in good health. They retain more than they excrete, and growth results. Adults usually show a negative or an even balance, retaining only that required for maintenance. When N excretion balances intake, N balance is said to exist.

Deficiency of specific amino acids is a metabolic disease, depending on whether or not the deficiency is relative or absolute. Ie.: relative to diet or dependent on body function. Caloric requirements also must be met by accessory food sources to prevent protein deficiency.

Relation to Clinical States

Clark 15 noted that a high protein diet appeared to eliminate the latent period in wound healing. Liver damage healing after chloroform injection is delayed on low protein diets. 16 In man, there is a varied loss of N, sulphur, phosphorus, and potassium in moderate or severe trauma. Fractures, dislocations, lacerations of soft tissues, surgical incisions, and infusions, are recognized etiologies of protein depletion. This cannot be accounted for merely by muscle material loss alone. It appears that there is a generalized catabolic increase to meet metabolic needs of recuperation. More foods high in proteins will prevent excessive losses, but do not appear to prevent local deterioration. High protein diets are therefore exceptionally helpful during convalescence. It is known that increased body temperature increases metabolism, 17, 18 but no attempt to maintain N balance in fevers has yet been successful.

Autopsy studies of absolute protein deficiencies are rare. Other complications usually develop prior to extreme states, masking the protein deficiency. Atrophy of the musculature, heart, liver, and thyroid gland occur. Histologically, the fat droplets are missing, and glycogen deposits absent from the liver.

Dependent edema and lowered serum albumin are usually found in hypoproteinemia. Salt and water intake are usually high. Edema is seen in legs late in afternoon, migrating to hands and face in the morning, explained by postural changes.

Recovery from wasting diseases may be related to

an abnormal requirement for essential amino acids. In the anemic dog19 high protein diets and iron were found of highest value in restoring serum albumins, globulins, and Hb. In nutritional edema the albumin fraction is lowered, and the globulin fraction variable,20, 21

There is no convincing evidence indicating the causation of hypertension from high protein diets. Indeed, in the edema of nephritis, with no increase in blood N, 90-120 gms, per day protein diets frequently succeed in controlling the edema. Strauss²² found high protein diets helpful in controlling pregnancy toxemias.

As for low protein diets, Rose, C. and Berg23 imply that excess base might aid in establishing and maintaining low N equilibrium. Vegetarians may thus live.

Immunity Relationship

Autibodies have been found to be globulin molecules whose synthesis is somewhat altered when antigen enters the body.24 Bigler25 and Cannon26 have concluded that antibody production should be influenced by the same conditions which determine globulin production; moreover, as globulin production is dependent on amino acid intake and is impaired by inadequate such intake, it must similarly depend on protein ingestion and use.

Madden and Whipple 27 show that fabrication of normal serum globulin is dependent on intake and utilization of adequate amino acids. This is demonstrated by their work with rats. Using washed sheep's red blood cells as an antigen, injections were made with a 0.25% suspension into subject rats,—one group of which were then fed normally with all requisites, and the other group placed on a markedly reduced amino acid diet. Comparison of blood serum samples before injection with those taken 8 days after antigen injection showed hemolysin titres for the normal group sera to be 10 times higher than those in the low amino acid group. Furthermore, the latter group manifested definitely increased tendency to develop spontaneous infections.

Hypoalbuminemia and hypoglobulinemia were present in the low protein (amino acid) group, with diminished concentration of englobulin and pseudoglobulins 1 and 11.

Administration of complete amino acid diet to the low intake group showed quickly evidenced recovery to capacity to produce specific antibodies.

Schoenheimer²⁸ has concluded that antibody actions in metabolic reactions involving dynamic exchange with dietary N strongly suggests the same positive correlation between diet, intake, and antibody formation. Thus, if the antibody, or immunologic potential response varies quantitatively with available protein reserve, a luxus protein diet is of ESSENTIAL value in immunizations against specific diseases.

Dietary Requirements

Requirements of amino acids vary with the individnal, age, and state of tissue. Macy's recommendations are an average. Safety factors require a generous allowance above average. Dietary habits are a variable factor.

Forbes²⁹ and others hold that a nutrient is never, under any circumstances, metabolized by itself, regardless of its source, endogenous or exogenous; and that the dynamic effect depends on the amounts and kinds of nutrients with which it is utilized, plus length of time since last ingestion of food. This is borne out in the experiments of Corry Mann with healthy boys.³⁰ Moser⁴ found that about 2/3 of the complete lunch group, as compared with about 1/2 of the partial lunch group, made 110% or more of the average annual gain in height of American children of corresponding age and sex. The former received more milk and whole grain cereals than the latter.

SUMMARY AND CONCLUSIONS

- 1. Calculations on Moser's 4 survey data show marked amino acid deficiencies in many South Carolina diets. Even after allowing a generous survey error factor of 50%, the deficiencies are yet marked. Low energy levels, disease resistance, occasional patent dietary deficiencies, and vague physical signs of undernutrition were noted. In extreme cases the diets were cereals, fat meat, and few vegetable supplements. Pregnancy and lactation occurred in some inadequate cases. Although medical surveys of these cases are not available, it may be assumed that such a survey would show total deficiency states in varied phases.
- 2. Definitely higher antibody titres are had in experimental animals on diets containing adequate essential amino acids. It may be reasonably assumed that the same mechanism holds true in humans. Diet—then—is the foundation stone for successful immunization and for inherent disease resistance.
- 3. From the growth standpoint in children, the dietary analysis of Graph No. 3, and the isolated case of one child's growth gain, indicate clearly the need for balanced diets containing adequate complete proteins, as well as all other factors.
- In any disease state, nutrition—from its relation to body resistance, is a priority requisite for prompt recovery.
- 5. Principal factors influencing nutrition include climate, population density, economic factors, animal nutrition, vitamin and mineral sources, and intake. Protein supply is correlated with all these factors, principally population density and available food sources. World War II demonstrates the effect of deficient diets coupled with disease.
- 6. Today protein furnishes 9.5–17% of total calories required by many of our population—some in the 10-14% range. 50% of this protein is in fair to good diets. Poor diets lack protein content,7 of adequate amounts. Those diets providing adequate amounts of milk, eggs, meats, and vegetables, provide

- ample safety factors of amino acids, vitamins, minerals, iron, rare elements, and a portion of caloric requirements.
- 7. Since man cannot store the 8 known essential amino acids, a daily supply is required. Maintenance amounts are quite small, but disease, injury states, and growth, require increased intake. Adult health—with particular reference to geriatrics—calls for a well balanced dietary. Proper intake or fortification of foods must be assured as a prophylactic measure.
- 8. Many American diets derive 1/8 caloric value from protein, 1/3 from fats, and the remainder from carbohydrates, with little regard for biologic value of proteins or correct calorie protein relationship. Hence, proteins supplied from animal and plant sources should assure adequate amounts of indispensable elements.
- 9. Hypoproteinemic states found by the medical profession are complicated by caloric, vitamin, and mineral deficiencies. At present a clear cut picture of frank essential amino acid deficiency may best be illustrated by controlled laboratory conditions. That such conditions may otherwise exist is assumed.
- 10. With excessive loss, or requirement of protein, the intake should be at least 2-3 times normal until metabolic adjustment occurs. It is significant that plasma infusion raises blood protein levels in certain clinical states, but shortly thereafter these levels decrease—indicating use or excretion. This point, although not yet quite clear, deserves further study.
- 11. Increased income results in increased animal protein intake of the complete protein foods. Low income presents the problem of providing a suitable and enticing substitute.
- 12. There is no indication that changes in organs of normal animals fed on abnormally high protein diets show anything more than normal physiologic response to increased functional demands.
- 13. Meats as protein sources are most ideal. Substitution of fats and carbohydrates occurs when lean meats are not available. Satisfactory substitutes of as high biologic value are a necessity.
- 14. Benefits to the population from nutritional education will result in better stature, weight ratios, stronger children and adults, lessened incidence of disease, better morale, higher response to the complexities of modern life, and increased productive ability and efficiency.
- 15. The problem cannot be effectively approached except through our educational agencies by adequate extension of facilities available in our academic and medical colleges, and Public Health agencies.

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The Journal of the South Carolina Medical Association

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JUNE, 1948

HIGHLIGHTS OF THE CENTENNIAL

With 450 members registered (44% of the membership of the Association), the recent meeting in Charleston had the largest attendance on record. This number did not include the wives of physicians—over 200 of them—who came with their husbands.

The printed program, prepared by Dr. Joe Waring and his committee, was unique and attractive. It not only included the usual order of business, pictures of officers, and announcements, but also several pictures of old Charleston.

The House of Delegates had a full docket, but the meeting was run with efficiency and without waste of time by Dr. Olin B. Chamberlain. Most of the committee reports had been mimeographed and copies were furnished to the members. It is evident that the Association is carrying on work in various fields, and that plans are being made for increased activity during the coming year.

Following spirited but orderly voting, Dr. Roderick MacDonald was elected President-elect. The other two nominees were Dr. A. W. Browning of Elloree, and Dr. George Wilkinson of Greenville. Dr. W. R. Tuten of Fairfax was elected Vice-President. As Chairman of Council, Dr. MacDonald has shown capacities for leadership, and the Association is to be congratulated upon his selection and that of Dr. Tuten to office. Dr. C. S. McGants was elected to Council to fill the unexpired term of Dr. MacDonald. Other members of Council whose terms expired were re-elected, as were the members of the State Board of Medical Examiners and of the Board of Examination and Registration of Nurses.

Dr. James E. Paullin of Atlanta, past President of the A. M. A., and the official representative of that body, gave a stirring address in which he presented the problems which are facing the medical profession today. Dr. Warren Quillian of Coral Gables, Florida, official representative from the Florida Association, discussed the past and future of American medicine, as seen through the eyes of a pediatrician. He presented some of the findings of the recent survey on medical care of children which was made by the American Academy of Pediatricians, and discussed these in terms of our present conditions.

Dr. I. A. Bigger of Richmond, representing the Virginia Medical Association, discussed "Congenital Atresia of the Aesophagus," showing the progress which has been made in recent years in the treatment of this condition in children.

In one of the most practical papers for general practitioners which we have heard, Dr. Paul Beeson of Atlanta, representing the Georgia Medical Association, presented a discussion of "Chemotherapy in Acute Infections."

Representing the North Carolina Medical Association, Dr. V. K. Hart of Charlotte, discussed "Space Filling Lesions of the Nasal Sinuses and Respiratory Tract," illustrating his lecture with numerous slides.

In his inaugural address, printed elsewhere in this issue, Dr. Olin Chamberlain contrasted the problems which faced the doctors of a century ago with those which are present today, showing their similarities and their differences. His paper should be read with care by every member of the Association.

The "Recent Advances Program," on the last morning of the session, was well attended and well received.

The number of commercial exhibits reached an alltime high, and they were well attended by the physicians. Many of the exhibits stressed the theme of the Centennial and of particular interest were the reprints presented by Mead Johnson and Company, as souvenirs of the occasion. This brochure consisted of "An Account of the Weather and Diseases of South Carolina," by Dr. Lionel Chalmers, of Charles Town, S. C. This was originally printed in London in 1776. Lionel Chalmers is frequently referred to as the first pediatrician in this country.

The Charleston physicians lived up to their tradition as genial hosts. On Thursday evening they had the entire Association as their guests at the Dock Street Theatre for a special presentation of "Dream Girl." Following the play delightful refreshments were served to all.

The annual banquet held at Ashley Park was a memorable occasion with over 500 present. The speaker of the occasion was Dr. Reginald Fitz of Boston, whose general theme was friendliness. In a scholarly and witty vein, he described the close ties which have bound the Medical Associations of Massachusetts and South Carolina through the years.

For his untiring work in behalf of the Association, Dr. Olin Chamberlain was presented with a beautiful silver tray. The presentation was made by Dr. James Young of Anderson, speaking on behalf of all the members.

A gift was also presented to Dr. J. I. Waring, in appreciation of his work as general chairman of the arrangements, and for his preparation of the history of the Association. This gift was presented to Dr. Waring by Dr. Chamberlain.

When Dr. Joe Waring presented us with a copy of "The History of the South Carolina Medical Association," he remarked casually, "Here it is. I doubt if it will be read very carefully, but I hope some will enjoy it." His statement proved to be far from accurate. Members eagerly sought to obtain their copies of the history and it provoked the greatest of interest and appreciation. Each member of the Association is entitled to one copy and those who did not receive theirs at the meeting will be mailed a copy in the near future.

The members of the Woman's Auxiliary attended in large numbers and played a large part in the social activities of the Association. It is becoming evident that not only physicians, but their wives look forward to the annual meeting, and we predict that as years go by, more and more of our wives will go with us to these meetings.

Many individuals played a part in making plans for the Centennial but to two members and to one group of physicians must go the main credit for the success of the Centennial. Dr. Olin B. Chamberlain, President, spared no effort in arranging the program. Dr. Joe Waring, Chairman of the local committee on arrangements, worked untiringly, and the physicians of Charleston were most generous in their efforts and with their money, in sponsoring the social features. To these individuals the entire Association is truly grateful.

MEETING OF COUNCIL

Francis Marion Hotel, Charleston, S. C.

May 12, 1948, 10:00 a.m.

Meeting called to order by Macdonald, Chairman, with the following members present: J. B. Latimer, J. C. Sease, W. W. Boyd, C. R. F. Baker, J. W. Chapman, L. P. Thackston, J. H. Stokes, R. B. Durham, O. B. Mayer, 11ngh Smith, M. L. Meadors and J. P. Price.

The Secretary presented his annual report which was received as information. The financial statement of the Association was presented and discussed. The Treasurer was instructed to give a bonus of \$250.00 to Mrs. Claude G. Watson, Business Manager.

The report of the Director of Public Relations was heard and received as information. Following a full and free discussion a motion was passed instructing the Treasurer to pay Mr. Meadors a bonus of \$1,000,00.

Following a discussion of legislation now pending in the national Congress, a resolution was adopted for submission to the House of Delegates opposing that part of the proposed draft law which would subject physicians up to the age of forty-five to the draft.

A letter was received from the South Carolina Gynecological and Obstetrical Society requesting the appointment of a special committee on maternal welfare. The President was requested to appoint such a committee.

The Secretary presented a lapel emblem which had been furnished by the Indiana Medical Society and which was being presented to all members of that organization after fifty years of practice of medicine. The Secretary was instructed to secure a similar type of emblem with appropriate engraving, to be presented to members of our Association who had practiced medicine for fifty years.

A letter was presented from the South Carolina Hospital Association relative to a campaign for recruiting nurses and our Association was requested to make a contribution of \$750.00 to this campaign. The Chairman was asked to appoint a special committee to look into this matter.

Upon petition from the Greenville County Medical Society the following men were made Honorary Members of the Association since they had retired after having been members in good standing for over twenty-five years: Dr. Charles H. Fair, Greenville; Dr. Alva S. Pacl, Greenville.

Because a recent illness had forced him to miss the last two meetings of Council, Dr. W. W. Boyd

tendered his resignation as a member of Council. Council refused to accept the resignation and Dr, Boyd was asked to continue to serve as a member of Council.

Council adopted a resolution commending the State Board of Medical Examiners for the stand which had been taken relative to refusing to grant the privilege of examination to graduates of Grade B and unaccredited medical schools.

A letter from Radio Station WRNO, Orangeburg, S. C., to Dr. C. A. Mobley of Orangeburg, relative to a proposed radio program advertising Edgewood Sanatorium, was presented to Council with the request that Council render an opinion as to the advisability of such a program. Following a full discussion Council voted against such a program feeling that it would be inadvisable for a medical institution of this character to enter the field of commercial advertising.

Following a report from Dr. R. B. Durham concerning the recent conference in Chicago on National Emergency Medical Service, the President of the Association was requested to appoint a special committee to consider the question of civilian defense and to submit definite plans to Council.

A request was received from the South Carolina EENT organization relative to some action regarding Cedar Springs. After a full discussion Council voted to take no action until more specific information and recommendations were made.

After a full discussion of the annual directory which is printed each fall, the Secretary was instructed to enlarge this year's directory so as to include pertinent information relative to each member of the Association in addition to the usual alphabetical and geographical listing.

Mr. James Ragsdale representing the American Policy Holders Company, a subsidiary of the American Mutual Liability Insurance Company of Boston, appeared before Council and presented a special contract for protection against malpractice suits, which would be sold only to members of the Association. Following a full discussion with considerable questioning, Council endorsed the contract as being acceptable and advised the Secretary to furnish Mr. Ragsdale with a letter to that effect which could be sent to the members of the Association. Council endorsed its policy of refusing to enter the insurance field and to sell insurance but asserted its willingness to consider and to approve or disapprove any insurance contract submitted by a reputable insurance company.

Mrs. David Adcock, President; Mrs. P. M. Temples, President-Elect, and Mrs. J. L. Sanders, Treasurer of the Woman's Auxiliary, appeared before Council and submitted their annual reports. Following a general discussion Council adopted a resolution instructing the Treasurer to send to the Treasurer of the Woman's Auxiliary the sum of 50c (fifty cents) per member of the Association per year for the work of the Auxiliary. It was understood that should the Auxiliary need additional funds a specific request would be sent to Council for consideration. Council voiced its thanks to the ladies for the reports which they had submitted and for the cooperation which they had afforded the Association during the past year.

There being no further busines the Council was adjourned.

Julian P. Price, Secretary

MEETING OF COUNCIL Morning of May 13, 1948 Charleston, S. C.

The following officers were elected: Chairman, Dr. O. B. Mayer; Vice Chairman, Dr. L. P. Thackston; Editor, Dr. J. P. Price.

Adjournment.

J. P. Price Secretary

THE TEN POINT PROGRAM

STATE HEALTH COUNCIL TO BE ORGANIZED

One of the most important developments in the work of the Association within the past few weeks, and one that is directly in line with the Ten Point Program, was the beginning May 6th toward organization of a State Health Council in South Carolina.

The meeting of leaders in organizations interested in the promotion of good health, which was held at the Wade Hampton Hotel in Columbia, was the direct result of the work of the Association's Committee on Bural Health, Dr. Harold S. Gilmore, Nichols, Chairman. The other members of Dr. Gilmore's Committee, who share credit for the planning and arrangement of the meeting, were: Dr. A. W. Browning, Elloree; Dr. M. H. Boggs, Abbeville; and Dr. J. A. Hayne, Jr., Hampton.

The purpose and plan of the meeting, as indicated in this column last month, was to bring together, not simply doctors, but leaders from as many of the lay organizations as possible, who are interested in the promotion of health and good medical care, for a discussion of problems in these fields in South Carolina.

While perhaps we would plead guilty to a charge of

being a rather prejudiced observer, it seemed to us that the meeting was highly successful. That view was justified by the enthusiasm expressed by many of those who attended, and by their very evident desire to cooperate in just the sort of thing that Dr. Gilmore and his Committee had in mind in planning the meeting. As will be observed from the list of speakers, all of whom are prominent leaders in their particular fields, and the subjects which they treated, those attending the conference heard presentations by people who knew whereof they spoke. Some of them were truly experts. At the conclusion of each address, there was a brief period for discussion, and many of those present participated in the discussions with interest. Following is the complete program:

Statement of Purpose of Conference—Dr. Harold S. Gilmore, Nichols, Chairman, Committee on Rural Health. South Carolina Medical Association.

"Nutritional Needs of the People in South Carolina," Mr. D. W. Watkins, Director, Clemson College Extension Service.

"Health Needs in Industry," Mr. R. C. Edwards, President, Abbeville Mills, Abbeville.

"The Hospital Situation in South Carolina," Dr. C. L. Guyton, Director, Hospital Division, South Carolina State Board of Health.

"Problems of Health Among School Children." Miss Katherine Edwards, Consultant in Health Education, South Carolina State Department of Education.

"Rural Health—Its Present Condition and Needs," Mr. Neville Bennett, Clio.

"Health in the Rural Home," Miss Jane Ketchin, Assistant Home Demonstration Agent.

"The Problem of the Chronically Ill in South Carolina," Dr. W. R. Mead, Florence.

At the conclusion of the papers, there was a report from the Committee on Resolutions, which recommended the appointment of a Steering Committee to go further into the plan for organization of a State Health Council. The Resolution embodying this recommendation was adopted unanimously by the group. Those named to this Steering Committee of nine are as follows: Dr. Harold S. Gilmore, Chairman, Nichols; Mr. M. L. Meadors, Secretary, Florence; Miss Katherine Edwards, Columbia; Miss Jane Ketchin, Rock Hill; Mr. W. W. Loranz, Sumter; Mr. E. M. Goldsmith, Greenville; Mr. O. G. Dorn, Sumter, Mr. R. C. Edwards, Abbeville; and Dr. C. L. Guyton, Columbia.

Twenty-three organizations responded to the invitation to attend the meeting on May 6th, and the total number present was about 60. It is hoped that all the members of this Association will take note of the effort begun with this meeting and will give their sympathetic interest, and cooperation if called upon, toward the organization and work of the State Health Conneil, as it develops.

Dr. Julian Price acted as Chairman of the Committee on Resolutions, at the Columbia meeting. Those attending the conference were guests of the South Carolina Medical Association at lunch.

THE WOMAN'S AUXILIARY

Under the leadership of its President, Mrs. David F. Adcock, of Columbia, the Woman's Auxiliary to the South Carolina Medical Association has made great progress during the past year.

With apparently indefatigable energy, Mrs. Adcock and her staff have attended meetings, District, State and National; organized new Counties and Districts; worked for greater membership in organizations already existing; and planned and promoted a concrete program for the Auxiliary. The results are beginning to be evident.

The business and social program planned and carried out by the Charleston Auxiliary was both interesting and constructive, and, we are informed, was greatly enjoyed by the members and their guests.

The worth of the Auxiliary depends in large measure upon its recognition and acceptance by the parent organization—the South Carolina Medical Association.

The thought was well expressed by Mrs. Hutchinson, President of the Richland County Auxiliary, in an article in the most recent (May) issue of the Auxiliary Bulletin. Her subject, "Broader Horizons," indicates a breadth of vision on the part of the leaders of the Auxiliary which is a credit to them, and her article raises a question which should be considered seriously.

"Are our medical societies sufficiently aware of us?", asks Mrs. Hutchinson. "Have they given us the encouragement, the recognition, the faith that we need to make us see broader horizons? Have they given us the opportunities for service that we could bring to realization for them? Frankly, they have not. Two years ago our State Medical Association awakened to our potential abilities and gave us the financial aid for which we are indeed grateful. Two years ago they gave us the Bulletin to keep us abreast of current medical legislation, for which we are also grateful. This year, under the capable leadership of our State President, Mrs. David F. Adcock, the BULLETIN has become the voice of our organization. And when we have a voice, we speak.

"The day has passed when the ladies of the Auxiliary were willing to content themselves with a cup of tea at a pleasant social gathering. They should not be content with simply this. We are living in an aggressive age, in an age when things are being challenged on all sides of us, when even the standards and mode of practice of the medical profession are being challenged. Can we sit idly by and sip at a cup of tea in the face of all this?

"We do not ask to be given a little chore here and a little chore there. Our lives are much too full and "...pressure of the gravid uterus mechanically interferes..."

in pregnancy

"Constipation is the rule. The pressure of the gravid uterus meehanically interferes with the function of the small intestine and colon per se and also renders the aet of defeeation less efficient by its effect on the diaphragm, abdominal museles and levator ani."

> -Bockus, H. L.: Gastro-Enterology, Philadelphia, W. B. Saunders Company, 1946, vol. 3, p. 999.

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busy with the manifold duties of ordinary living for that. We simply ask that our medical societies wake up to our potentialities, as our State Association has done. Become aware of us, of our desire for loving and loyal service. Give us those broader horizons. But beneath it all give us faith. Give us faith in ourselves and faith in what we are trying to do. For is not faith 'the safety net which lets us try to walk the rope of courage tight and high'?"

REFLECTIONS ON THE NATIONAL HEALTH ASSEMBLY

Three things particularly impressed us about the National Health Assembly in Washington, the first of May.

First, there was the attitude of the representatives of those groups which are the strongest advocates of compulsory health insurance. Their thought is not "if" but "when" we shall have compulsory health insurance. The only question which apparently remains in their thinking is "how long?".

Second, we believe that nearly everyone at the Conference was impressed with the willingness and ability of representatives of the medical profession, including a number who are high in the councils of the A. M. A., to sit down with leaders of labor, social service organizations and other similar groups and discuss the problems on common ground, with apparently a mutual desire to reach an understanding satisfactory to both. The thought was expressed that if the Assembly did nothing else, it had caused many laymen to realize that doctors can be reasonable and can see the other side of the picture, while those representing the opposite school of thought appeared to realize that there might, after all, be some basis for positions which have been taken by the medical profession.

The third important impression which we brought from the meeting, was of the fairness and forthrightness of Mr. Ewing, the Federal Security Administrator, in his conduct of the sessions over which he presided, and apparently in his direction of the general plan and arrangement of the meeting. There was no mistaking his position on compulsory health insurance. He made it clear in so many words, but, while we do not agree with his thinking, we admire his honesty, not only in saying openly where he stands, but in giving the opposition full opportunity to be heard and to make their position clear in the various sections and in the general meetings. There were one or two instances in which he was clearly irritated by certain of the tactics of those whose basic philosophy is the same as his own.

In view of the foregoing, we are unable to agree with one observation of Dr. Lull in a subsequent release, to the effect that the Assembly "seems to have caused about as much noise, nationally, as a ray of moonlight falling on a cup of custard." While that may be true so far as the noise is concerned, we do not believe that the importance of the meeting can be dismissed in such light phraseology.

It strikes us that with a man of Mr. Ewing's evident honesty of purpose at the head of the Federal Security Administration, the Assembly, conducted pretty generally on democratic principles and according to recognized parliamentary procedures, with the right and opportunity of free expression to all delegates, may contain the possibilities of the beginning of combined constructive thinking and planning on the part of the leaders in organized medicine, government, social service, and the other elements of American life, which is essential for any reasonable solution of the problem at hand.

Dr. Lull congratulates Mr. Ewing and his staff for their fairness and impartiality, and in this we fully concur. As to how the American Medical Association fared generally, this was the expression of Mr. Quincy Howe, Columbia Broadcasting System analyst, in his general summation of the meeting on the final day of the session:

"Some laymen may feel that the American Medical Association has been somewhat slow in coming around to health insurance and to the idea of government aid for health. But look at it from the doctor's point of view: Like all of us, doctors are creatures of habit, and they have learned their habits in about the hardest way there is. Just try to change some of your own habits. Try to stop smoking the way I did; or try pulling up stakes; try going to live in a new community, changing your profession—it isn't easy.

"Those of us who have been impatient with the American Medical Association for resisting change show a sad lack, I think, of understanding of human nature. Doctors have to make so many sacrifices. They submit themselves to so many disciplines, they are so overworked just keeping up with their own jobs that the wonder to me is that any of them have time for anything else. And it is only natural that those who do not interest themselves in something beyond their engrossing daily tasks want to hold on to their own tried and tested way of doing things.

"That so many doctors not only have taken the time to work with the National Assembly, but have shown themselves so cooperative, so understanding, so openminded, seems to me the most promising and the most important development of this whole meeting."

THE BROOKINGS REPORT

Amid the welter of criticism and demands for change in the present system of administering medical care in the United States, it is both heartening and refreshing to find in the report and recommendations of an impartial group of analysts, recognition of the advantages of the present system, and of the fact that, whatever its disadvantages, it is preferable by a wide margin, to anything government may have to offer by way of compulsory health insurance.

The report of the Brookings Institution was released opportunely, about the time of the meeting of the in common allergies

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National Health Assembly and surely it should not be too much to hope that it too will be given consideration by the Federal Security Administration, in making its report to the President on the results of the Assembly.

The conclusions and recommendations of the Brookings Report are quoted in full below:

"CONCLUSIONS:

The conclusions based on this foundation are:

- I. Probably no great nation in the world has among its white population better health than prevails in the United States. A few small homogeneous countries, such as New Zealand with respect to its white population, are slightly ahead of the United States as a whole, but certain States of the United States with larger populations equal them.
- 2. It is apparent that the United States under its voluntary system of medical care has made greater progress in the application of medical and sanitary science than any other country. This progress is now reflected in low mortality and morbidity rates of infectious diseases and in increased life expectancy. There is every reason to believe that these trends will continue imabated under our present system of medical care.
- 3. The nonwhites in the United States have materially poorer health than the whites, but the evidence does not indicate that this condition is primarily or even mainly due to inadequacy of medical care.
- 4. The advances in health among both the whites and the nonwhites that have been made in the United States in the past four decades do not suggest basic defects in the American system.
- 5. Although the statistics resulting from the administration of the Selective Service Act—the so-called draft statistics—have been widely used to show bad health among the American people and the need for revolutionary changes in arrangements for medical care of individuals, they are unreliable as a measure of the health of the Nation and cannot be used to show the extent of the medical needs of the country as a whole.
- 6. Present medical care in the United States compares favorably with that which existed in other leading nations prior to the Second World War.
- 7. The conditions in extremely poor rural areas that lack the resources to support adequate public services, such as health work, education, and highways cannot be satisfactorily solved by subsidies. This problem calls for a radically different approach, either bringing in new or improved economic activities or getting the people to more favorable and administratively less expensive areas. This condition has been accentuated by the emigration of youth from these areas to urban communities.
- 8. The United States has some individuals and families not possessed of the resources to enable them

- to pay for adequate medical care. In the future, as in the past, provision must be made for them through public funds or philanthropy. The evidence suggests that many of them are elderly, impaired, or underendowed or are widows or deserted women or their dependents. It is doubtful if they could be effectively covered by compulsory insurance because they would lack the means to attain and maintain an insured status. The large majority of American families have the resources to pay for adequate medical care if they elect to give it a high priority among the several objects of expenditure. The issue is not whether they can afford medical care but whether they should be compelled by law to pool their risks and to give payment for medical care a top priority. The major alternative for people with ability to pay is to leave them free to determine for themselves what medical care they desire and whether they will pool their risks through voluntary arrangements.
- 9. Compulsory health insurance would necessitate a high degree of governmental regulation and control over the personnel and the agencies engaged in providing medical care. This field of regulation and control would be far more difficult than any other large field previously entered by the Government, and past experience with governmental regulations and control in the United States causes doubt as to whether it encourages initiative and development.
- 10. The problem of eliminating politics from Government administration is extremely difficult. It does not seem probable that politics could be eliminated from medical care supplied under a governmental system.
- 11. Compulsory insurance would inject the Government into the relationship between practitioner and patient. A real danger exists that Government actions would impair that relationship and hence the quality of medical care.
- 12. The administration of compulsory insurance would require thousands of Government employees for accounting, auditing, and inspection and investigation.
- 13. The cost of medical care presumably would increase because of (a) administrative expenses; (b) the tendency to insured persons to make unnecessary and often unreasonable demands upon the medical care services; and (c) the tendency of some practitioners and agencies to take advantage of the system for their own financial advantage.
- 14. The adoption of compulsory insurance would not immediately make available adequate service for all, because there are not at present the facilities nor a sufficient number of trained and experienced physicians, dentists, and nurses to meet the demand which would result from compulsory insurance.
- 15. Proposals for compulsory insurance provide for payment of practitioners under one or all of three methods: (a) fee for service, (b) per capita, or (c)

salary. Use of the fee-for-service device represents the minimum degree of socialization, but it is administratively difficult. Administrative difficulties would probably result in the adoption of the per capita system which represents a higher degree of socialization or even in the salary system which represents practically complete socialization. It seems questionable whether a country which once embarks on compulsory insurance can turn back but must attempt to remedy defects by more complete government control and administration.

RECOMMENDATIONS:

- 1. For the present, in our judgment, the National Government would be wise to leave to the individual States the question of whether compulsory health insurance is to be adopted or whether the provision of professional services is to be left in the realm of free enterprise. It seems highly probable that in many communities the intelligent cooperation of consumers and practitioners will develop satisfactory arrangements that remain subject to their own control without National Covernment administration. It seems highly improbable that this experimentation—possible under our Federal form of government-will ultimately develop a single pattern that is applicable to all sections of the country and is desired by a large majority of the people. If such a pattern should develop, it will doubtless then be adopted with a great degree of unanimity. If compulsory insurance should be adopted now by a narrow vote in the Congress, thousands of persons who are opposed to it would start hostile to the whole undertaking.
- 2. For the time being the National Government and many of the State governments may well devote their resources and energies to:
 - (a) Research and developments in the fields of public health;
 - (b) Health education at the school level;
 - (c) Teaching of preventive medicine;
 - (d) Assisting in the acquisition of physical facilities and training of personnel;
 - (e) Provdiing systematic care for the indigent and

the medically indigent. In some States careful surveys of existing conditions will be required to furnish the basis for developing a comprehensive and coordinated program,

3. From the standpoint of public relations, governments might well be advised to leave adult educational campaigns for the control and prevention of disease to the national, state, and local voluntary organizations which have been able to enlist the active cooperation of leading laymen in most sections of the country. It must be remembered that good health is not exclusively a matter of medical care; it also impinges upon causative factors that are nonmedical, such as food, shelter, vice and crime, transportation, and industry. Its maintenance depends also upon the intelligence, interest and cooperation of individuals, families, and local communities.

These recommendations are not widely at variance with those of the majority of the Committee on the Costs of Medical Care, arrived at in 1932 after a comprchensive study.

The years since 1932 have witnessed-

- 1. A great growth in voluntary insurance both for hospitalization and for medical services.
- 2. State experimentation with compulsory health insurance in Rhode Island and California.
- 3. A growing willingness on the part of practitioners to cooperate in the development of prepayment plans and other devices to enable patients who so desire to regularize their payments for medical care.
- 4. A profound change in the amount and distribution of the earnings of the American people. This change greatly reduces the number who cannot afford adequate medical care if they desire to purchase it.

The experience of the United States since 1932 seems to have demonstrated the wisdom of these recommendations of the ma'ority of the members of the Committee on the Costs of Medical Care. It would seem unwise at this time to substitute for these developments a system of compulsory health insurance by national law which would have the unfortunate tendency to free policies and eventually retard medical progress."

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ABSTRACTS

The Treatment of Granuloma Inguinale With Streptomycin

Harold L. Hirsh, M. D. & S. Ross Taggart, M. D. Am. J. Syph., Gonor., and Ven. Dis. 32:159, March 1948

The article reports the results in the treatment with streptomycin of 21 unselected cases of Granuloma Inguinale. All the patients were Negroes, 11 men and 10 women, ranging in age from 19 to 48 years. The lesions ranged from ulcerations to granulomatous masses involving buttocks and perineum. The total daily dose used was one gram given intramuscularly in equally divided doses at four hour intervals for a period of time ranging from 6 to 47 days. Within 24 to 48 hours after the start of therapy the lesion became essentially painless; by the end of a week the skin was growing in from the margins of the ulcers; the granulomatous masses began to decrease in size after a week to ten days of therapy and continued to do so after treatment was discontinued, except in the case of a patient with a squamous cell carcinoma at the same site. At the end of two weeks no Donovan bodies could be demonstrated in biopsy specimens from the lesions. There were no relapses or recurrences in any of the patients followed for periods of time up to 14 weeks.

The authors state that while it is too early to endorse completely the treatment of Granuloma Inguinale with streptomycin, one can afford to be optimistic, since the above excellent results have also been obtained by two other groups working on the problem. The criterion used by the authors was to continue the anti-biotic until there was evidence of complete healing of the alcerative lesions. They state that the total daily dose should not be below one gram, and that it would seem reasonable to discontinue streptomycin when the Donovan bodies can no longer be demonstrated in the lesions. They conclude that streptomycin is the drug of choice in the treatment of Granuloma Inguinale.

Disasters Following the Operation of Ligation and Retrograde Injection of Varicose Veins,

> Luke, J. C. & Miller, G. G.: Ann. Surg., Vol. 127, No. 3, pp. 426-431, March, 1948.

Since the operation of high ligation and retrograde injection of the saphenous vein has become popular in the treatment of varicose veins and since it is relatively easily carried out, it has come to be considered comparatively free of hazard. However, the

authors believe that unfortunate results are occurring with increasing frequency, and the purpose of this paper is to point out 21 such cases and to offer suggestions which might decrease the incidence of complications. The serious disasters in the cases reported happened not only to occasional operators, but also to surgeons of great experience and high standing.

Hemorrhage from a torn varix near the saphenofemoral junction is not uncommon, and blind clamping often causes serious injury to the femoral vein, artery or nerve. Pressure is all that is required to stop bleeding until adequate measures can be taken. Ligation and injection of the femoral vein is sometimes done, when the saphenous vein is mistaken for a tributary, rather than the main vein. Cases are reported in which the femoral artery was ligated and injected by welltrained surgeons, thus necessitating subsequent midthigh amputations. Femoral arterial spasm immediately following the injection of veins may occur, producing severe pain in the extremity.

Of sixteen cases of deep thrombophlebitis four died from emboli; the twelve surviving patients have permanent disabilities.

To prevent the hazards mentioned, the surgeon must be thoroughly familiar with the saphenous vein and its relationships; he must have adequate operating equipment and experienced assistance. Immediate ambulation also appears to be of great value. Blind clamping is prevented by use of finger pressure, until the bleeding point can be properly identified. The authors suggest that no more than 5 cc. of any schlerosing solution be injected at the time of operation, and by drawing blood back into the syringe this solution may be diluted 3 to 1 with blood before injection.

If embolus should occur, removal of the clot in the vein by ligation of the superficial femoral vein is believed safer by the authors than the use of dicoumarol, but if ligation is not feasible, dicoumarol should be given with the usual precautions.

This report emphasizes that it is not intended to discourage the use of the operation of ligation and injection of the saphenous vein for varicose veins with incompetency, but to warn of the dangers and to offer a few suggestions as to how these dangers may be overcome.

Aerosol Therapy Giles A. Koelsche J. Allergy 19: 47-57, Jan. '48

The author discusses the treatment of diseases of the respiratory tract by the inhalation of mists pro-

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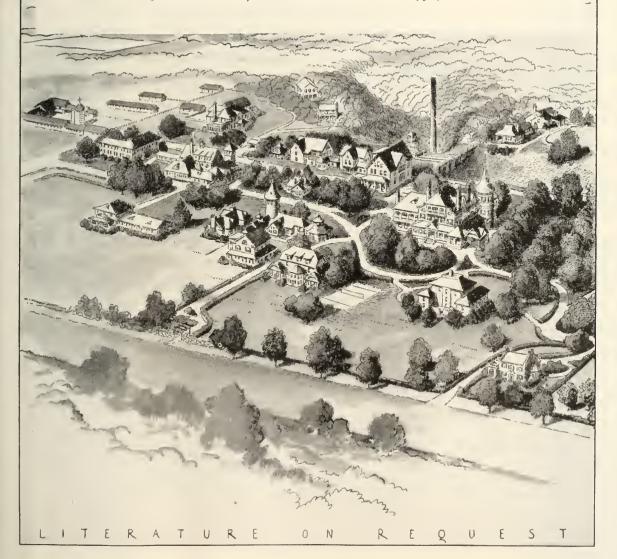
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ASSOCIATES

ERNEST H. ALDERMAN, M.D.
JOHN R. SAUNDERS, M.D.

REX BLANKINSHIP, M.D. THOS. F. COATES, JR., M.D.



duced by nebulizing medicated solutions. To insure therapeutic effectiveness, the particles of the medicated aerosol must be extremely minute. A satisfactory commercial product, the Vapoephrin vaporizer, is described. The stream of air necessary to effect nebulization is obtained from an oxygen tank.

Disease in which medicated aerosols have been used with benefit include bronchial asthma, sinusitis, bronchiectasis, bronchopneumonia, pulmonary abscess, acute laryngotracheobronchitis associated with edema, and severe pulmonary emphysema. The therapeutic agents employed include sodium sulfathiazole, penicillin, and streptomycin for bacterial infections of the respiratory tract; aminophyllin, epinephrin, and neosynephrin for allergic respiratory conditions. The dosages advised are as follows: 1% solution of epinephrin; 0.25% to 1% solution of neosynephrin; 10 to 20 cc. solution of 0.25 to 0.5 grams of aminophyllin administered intermittently or continuosuly; penicillin 30,000 to 50,000 units per cc; streptomycin 0.5 to 1.0 grams dissolved in 20 cc. of normal saline.

Aerosols of epinephrin or neosynephrin are of value

in relieving acute attacks of asthma; good results are also reported with the use of aminophyllin aerosol. Ammonium chloride may be added because it facilitated expectoration by liquefying tenacious sputum. Where the asthma may be due to bacterial infection. so called intrinsic asthma, penicillin is often beneficial. Acute and chronic sinusitis is another disease successfully treated with penicillin aerosol. The use of a vasoconstricting nasal spray just before starting the administration of penicillin aerosol is advised. Aerosols of the antibiotics are of real value in combatting the infection associated with bronchiectasis and in preventing postoperative complications. In laryngotracheobronchitis with edema aerosols of physiological saline with propylene glycol and penicillin directed into the tracheotomy opening have been used with good results. In pneumonia the intramuscular administration of antibiotics is still the preferred treatment but in cases due to streptococcus, staphylococcus, and klebsiella pneumoniae, the administration of antibiotics by aerosol may prevent such complications as formation of lung abscess. The results of aerosol therapy in cases of emphysema are not encouraging.

Pathological Conference, Medical College of the State of South Carolina

KENNETH M. LYNCH, M.D., PROFESSOR OF PATHOLOGY

ABSTRACT #563

Presenting: Student Creticos.

HISTORY: This is the case of a 12 year old colored boy who was first seen in the clinic in September 1937. His chief complaint at that time was pain in lower abdomen with accompanying swelling and pain in the chest of 2 years duration. Physical revealed a poorly developed and undernourished patient with sores on his arms, back and legs. Lymphadenopathy noted at that time. Wasserman was negative. Since that first visit he came to clinic fairly frequently for next 7 years complaining of chest pain, abdominal pain and joint pains. On several occasions rales were heard in his chest. Tuberculin in December 1937 was negative. Heart was found enlarged to right and left and a systolic murmur was heard. In 1940 systolic and diastolic niurmurs were heard over precordium and the sedimentation rate at this time was 13 mm. uncorrected. 65% sickling of erythrocytes in 24 hours was noted. From 1940 to 1944 patient was not seen in clinic. On February 23, 1944 he was admitted to Roper with chief complaint of "pains in head, hip bone and legs," fever, loss of appetite and malaise. He was rather stuporous, but further questioning revealed that there was soreness of elbows, shoulders, wrists, hips and joints of feet and ankles. These areas were stiff and tender to touch. His neck was similarly affected. His temperature was 101° and it spiked on

several occasions to 102°. His heart was enlarged and a blowing apical systolic murmur was heard. The sclerae were yellow and the liver was tender and palpable 5 cm. below the costal margin. He remained in the hospital 2 weeks. Jaundice gradually disappeared as did the pain and tenderness. The stiffness of the neck was last to disappear. On that admission laboratory findings were as follows:

Urine: Dark brown, Sp. Gr. 1.010-1.012, alb. + to ++. Bile 4 plus. Urobilin +.

Blood: RBC 2.4-3.9, Hb 8.5-11, WBC 15,000-11,000. Sickling 95%, 24 hours. 5% nucleated RBC. Sed. rate 41. Vandenberg direct +++++.

Stool: Greyish, no occult blood, ++ bile pigments. Benzidine test (urine) ++. Icterus 180-50. Wasserman negative. March 1, 1944—Two views of this skull do not reveal any evidence of sickle cell anemia. Discharged improved.

On 5/13/44 he returned to the emergency room complaining of fever and "hurting all over." T 104.6, P 128, R 28, B. P. 144/70. Examination revealed a thin colored boy, acutely ill and semicomatose. Sclerae were icteric. Dyspneic with visible pulsation of vessels of neck. Rhonchi over both lungs, but no imposement of resonance. PMI in 6th interspace in mid-clavicular line. Loud blowing systolic murmur "over entire chest" with accentuation of 2nd sound. Liver palpable. Knees and hips tender on



for injection

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LABORATORY: RBC 2.5 M; Hb 6 gm., WBC 40,000 with 82% polys, 17% lymphs, and 2% monos; 2% nucleated red cells.

Urine: Color dark amber to black; 1.012 sp. Gr.; \pm alb.; \pm hyaline casts; bile four plus. Sed rate 43 mm.

Wass. neg.; Prothrombintine 96%. Icterus index 66: Sickle cell preparation 40% immediate and 70% in 30 minutes.

COURSE IN HOSPITAL: Temperature varied between 98.6 and 105°. Nurses notes on morning of admission reveal that patient was coughing at frequent intervals. Later that afternoon projectile vomiting was noted. Day after admission the nurses notes showed that patient had incontinence of urine, crying out at intervals and not responding when talked to. On third day post admission one examiner noticed increased jaundice and comatose condition of patient. Rales were heard throughout both lung fields and breath sounds were increased. Respirations became rapid and shallow. On the fifth postoperative day the patient expired.

Dr. Ralph Coleman, Conducting.

Dr. Coleman: Mr. Davis, please give us your analysis of this case.

Student R. J. Davis: One can pretty well make a diagnosis of sickle cell anemia from the age, race, joint pains, icterus and laboratory findings. A stiff neck may be seen in sickle cell anemia and may simulate meningitis. The enlarged liver and the heart findings, together with the pain and aching all give support to this diagnosis. Fever and jaundice are often seen in crisis and I believe he had a crisis on both occasions. I think the leucocyte count here is higher than it should be, however.

Dr. Coleman: By what criteria do you establish the diagnosis of sickle cell crisis?

Student Davis: By chest, abdominal and joint pains, jaundice, stiff neck, fever and leucocytosis.

Dr. Coleman: How do you explain the direct van den Burgh?

Student Davis: I can't. It should be indirect. Severe jaundice may sometimes change reaction however.

Dr. Coleman: What about palpable spleen?

Student Davis: The spleen in sickle cell anemia at first is enlarged and then becomes small and fibrotic. The patient is young enough, so that duration of disease might not have resulted in an atrophic spleen.

Dr. Coleman: Mr. Freeman, do you agree with what has been said?

Student Freeman: I too think it is sickle cell anemia. This can explain most of the symptoms. As regards the 40,000 blood count—these people are very prone to develop secondary infection. I think he probably had this.

Dr. Coleman: What are the X-ray changes in sickle cell anemia?

Student Freeman: Skull shows thickening with thinning of cortex and increase in marrow trabeculations. These changes are not always present.

Dr. Coleman: What do you think was the cause of death?

Student Freeman: Bronchopneumonia. Enlargement of the liver might be indicative of some degree of congestive heart failure, but I would like two other symptoms before making a definite commitment along this line.

Dr. Coleman: Do you think the leucocytosis and temperature are consistent with sickle cell anemia?

Student Freeman: I think they could be this high in sickle cell anemia but bronchopneumonia would be a likely condition to elevate them above the level usually seen in an uncomplicated case of sickle cell anemia.

Dr. Coleman: What about the enlarged spleen?

Student Freeman: This finding is inconsistent. I thought these patients tended to splenectomize themselves.

Dr. Coleman: Mr. Furman, can you suggest any additional considerations?

Student Furman: Rheumatic fever should be considered and it may be difficult to differentiate between these two diseases. The joints may be affected in both, but usually have only 1 or 2 joints affected at a time in rheumatic fever. There is no jaundice in rheumatic fever and the fever and white blood count are not usually this high.

Dr. R. Pratt Thomas: Final Pathological Diagnosis: Meningo-encepholitis, acute, purulent. Siekle eell anemia.

This case illustrates the eventual outcome of many of these cases of sickle cell anemia. It also emphasizes the danger of a previously established diagnosis in that when one diagnosis has been firmly established there is a tendency to try to explain all subsequent events on this basis and to overlook other possibilities. I think the leucocytosis and fever were too high for uncomplicated sickle cell anemia and the patient too toxic.

The brain showed a thick greenish-yellow meningeal exudate that was particularly abundant about the brain stem. Microscopically there was heavy inflammatory involvement of ependymal linings of the ventricles as well, with extension of the suppurative process into the brain substance. Cultures of the meningeal exudate at the time of autopsy revealed a mixed infection consistent with streptococcus viridans and probably Friedlaender's bacillus. This was the cause of death.

I am sure the spleen was never palpated, as it weighed only 7 gm. and was transformed into a markedly shrunken fibrous structure.

The vessels in general were stuffed with sickled and elongated forms of erythrocytes and there was profound siderosis of the spleen.

CORRESPONDENCE

Dr. Julian Price, Editor South Carolina Medical Journal Florence, South Carolina

Dear Dr. Price:

For years the South Carolina State Board of Health has had a contract with E. R. Squibb and Sons. This contract has been cancelled by mutual agreement, and in the future the Service Section of the Division of Finance, State Board of Health, will handle all such orders for biologicals.

We would like for you to call attention to this matter

in the Journal.

All such communications should be addressed to:

South Carolina State Board of Health Biological Service Hampton Office Building Columbia, South Carolina

> Very truly yours, Ben F. Wyman, M. D. State Health Officer

Editor South Carolina Medical Association Journal Florence, South Carolina Dear Sir:

The Southeastern Section of the American Urological Association is in receipt of a fund to be used for Prize Essays presented before the annual meeting of this section. The Association will appreciate a notice in your journal announcing this prize which contains the following information:

The Southeastern Section of the American Urological Association announces receipt of a \$1000 donation from Mr. and Mrs. William R. McEwen, Fort Lauderdale, Florida. The fund is to be used to stimulate research on the problem of "Urinary Bladder Dysfunction." An award of \$250 will be made for the best essay presented before the Annual Meeting of the Southeastern Section. Competition is open to men who have graduated from Medical School within the past ten years. Further information may be obtained by writing to Dr. Russell B. Carson, 408 Sweet Building. Fort Lauderdale, Florida, Secretary-Treasurer of the Southeastern Section of the A. U. A.

Yours truly, Russell B. Carson, M. D. Secy., Treas.

DEATHS

WILLIAM ASBURY ROURK, JR.

William Asbury Rourk, Jr., 50, of Myrtle Beach, died at his home on May 18, 1948, after an illness of two weeks.

A Native of North Carolina, Dr. Rourk received his education at the University of North Carolina and at the Jefferson Medical College in Philadelphia (Class

of 1924). Following an internship in Philadelphia he located in Myrtle Beach where he practiced until his death

His cordial smile and his gift for friendship made Dr. Rourk one of the most popular physicians in the state. He was known not only to the year round citizens of Myrtle Beach but to a large number of summer visitors who had occasion to call upon him for his services. He was extremely active in the religious and civic activities of his own community, having served as Treasurer and Deacon in the Presbyterian Church and also as a member of the city council. Myrtle Beach will certainly miss his presence and his counsel.

Dr. Rourk is survived by his widow, the former Miss Gertrude MacDonnell of Philadelphia, and one son.

MANNING LIONEL NELSON

Dr. Manning Lionel Nelson, born in Charleston, November 1883, died in the Baptist Hospital, Columbia, February 21, 1948, after a brief illness.

Dr. Nelson received his literary education in the Charleston schools and at Belmont College, North Carolina. Entering the South Carolina Medical College, he first studied Pharmacy, then medicine, graduating with the class of 1909.

Dr. Nelson's thirty-eight years of active life as a physician were given to the town of North and vicinity. He married Miss Leila Bobo of North, who survives him. Their only child, Dr. M. L. Nelson, Jr., was killed in World War II, while serving in the Pacific area.

Dr. Nelson was devoted to the practice of medicine and gave unselfishly of his time to a large practice among people who loved and honored him not only as their physician but as their friend.

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WOMAN'S AUXILIARY SOUTH CAROLINA MEDICAL ASSOCIATION

President: Mrs. P. M. Temples, Spartanburg, S. C.

Publicity Secretary: Mrs. W. H. Folk, Spartanburg, S. C.

PRESIDENT'S REPORT

To serve as president of the Woman's Auxiliary to the South Carolina Medical Association is a real privilege, which has been fully realized and deeply appreciated.

Though the duties of the office are strenuous, this year has been a pleasant and interesting one, and has been unusually significant in many ways.

During my term of office I have enjoyed the fullest cooperation from the Advisory Council and from every officer and committee chairman. In relinquishing this office I bespeak the same cooperation for my able successor, Mrs. Temples.

In accordance with the National program MEM-BERSHIP and PUBLIC RELATIONS have been stressed throughout the year, though all other auxiliary objectives have been closely followed.

Growth of the state Auxiliary has been extended by the organization of two new district units, composed of five counties each. This makes 12 local auxiliary mits in the state organization with a total of 28 of the 46 counties, organized. The membership of 545 is an increase this year of 140 members. The loss of three members through death is sincerely regretted.

The programs of the local units have been largely on health education. Cooperating with the program of Public Relations members of the Auxiliary have given freely of their time in all civic enterprises, have cooperated fully with other groups in promoting health programs and have participated in numerous drives such as the American Red Cross, Cancer, Tuberculosis, March of Dimes, Crippled Children and the like. One county Auxiliary conducted the Cancer Drive in its entirety.

South Carolina has been alert to the importance of the recruitment of student nurses. Every local organization has supported the campaign. Several intensive drives have been conducted by local auxiliaries throughout the state, with most gratifying results. There have been two nurse scholarships given.

Efforts to promote the circulation of the Bulletin and Hygeia have been rewarded with an increase in subscriptions to both periodicals.

The Student Loan Fund continues to be an active project, in the hope that it will grow into an adequate amount of money for use in the probable lean years to come. Historical research has been earried on in each local unit. More than 50 biographies of deceased South Carolina physicians have been collected this year, making the total of 401 on file. Six historical papers have been sent to the Southern Historian to be filed with the committee on the Romance and Research of Medicine. The request of Dr. Waring that pictures and biographies of all past presidents of the Association be secured was fulfilled 100%. Though that task required a considerable amount of correspondence it is a pleasure to report its completion. Doetor's Day, March 30, was fittingly observed in every local auxiliary.

The president has been present at every national meeting and the meeting of the Southern in Baltimore. Upon invitation, she has visited every county organization during the year, in addition to organizing two new ones, and accepted an invitation to speak to the

Business and Professional Women's Club of a neighboring town on "The Recruitment of Student Nurses."

Through the splendid cooperation of the Director of Public Relations of the Medical Association the realization of an Auxiliary publication has been made possible. The Auxiliary Bulletin is YOUR official organ. You are urged to use it freely, and to help it serve the purpose for which it is intended. To this publication and to the Journal of the Medical Association your president has contributed articles regularly.

Having accepted Dr. Waring's kind offer to provide a permanent storage space for the Auxiliary archives, it is a pleasure to report that all records of the state organization have been stored in the Medical College Library in Charleston, and can be referred to at any time by the officials of the Auxiliary.

Through the loyal and wholehearted support and cooperation of the South Carolina Medical Association, the Advisory Board, Officers, Councillors, committee chairmen, county presidents and active members of the Auxiliary the foregoing accomplishments have been made possible. The theme for the year, "Accomplishment Through Cooperation" has in some part been fulfilled, but we look forward with confidence to years of greater service and progress.

To see the Anxiliary steadily growing; to see understanding and cooperation between auxiliaries and medical societies constantly developing; to see advisory councils increasingly assuming the responsibilities of directing the work of the auxiliaries along constructive lines; to see education of the laity slowly and quietly, but surely progressing; to see fellowship increasing and fine friendships being formed; to know that auxiliaries are increasingly contributing toward unity, within the profession and better understanding between the medical profession and the public of the responsibilities of each toward the other; these and the joys that come from our pleasant social relationships in happy meetings like this, make membership in our organization an honor, and service a pleasure. Such results are full compensation for hard work.

Respectively submitted, Eloise Daniel Adcock, President (Mrs. David F. Adcock)

BROADER HORIZONS

Let us pause for a moment mid the hustle and bustle of our hurly-burly days and give new thought to the meaning of our beloved Auxiliary, Beloved it truly is, because it is the medium of our service to a profession which became dear to each of us the day we became MRS. DOCTOR. Of our time and our talents we have given unstintingly. Never once have we asked for praise or even recognition. That we have accomplished much, our records show—that we could accomplish even more, we already know. Why do we pause for thought? Why do we wish to take stock of the situation as it appears to us today?

That we are "going places", to use a cant expression, is within our ken. We have already arrived at many of the "places" which were our goal. Our watchword, SERVICE, has ever been before us. Service to others in a general sense, but service to the medical profession in a far more specific sense. Are our medical

societies sufficiently aware of us? Have they given us the encouragement, the recognition, the faith that we need to make us see broader horizons? Have they given us the opportunities for service that we could bring to realization for them? Frankly, they have not. Two years ago our State Medical Association awakened to our potential abilities and gave us the financial aid for which we are indeed grateful. This year, under the guidance of Mr. M. L. Meadors, Director of Public Relations of the South Carolina Medical Association, and the capable leadership of our State President, Mrs. David F. Adcock, the BULLETIN has become the voice of our organization. And when we have a voice, we speak.

The day has passed when the ladies of the Auxiliary were willing to content themselves with a cup of tea at a pleasant social gathering. They should not be content with simply this. We are living in an aggressive age, in an age when things are being challenged on all sides of us, when even the standards and mode of practice of the medical profession are being challenged. Can we sit idly by and sip a cup of tea in the face of all this?

We do not ask to be given a little chore here and a little chore there. Our lives are much too full and busy with the manifold duties of ordinary living for that. We simply ask that our medical societies wake up to our potentialities, as our State Association has done. Become aware of us, or our desire for loving and loyal service. Give us those broader horizons. But beneath it all give us faith. Give us faith in ourselves and faith in what we are trying to do. For is not faith "the safety net which lets us try to walk the rope of eourage tight and high?"

Hildegarde S. Hutchinson

Dear Members of the Woman's Auxiliary to the South Carolina Medical Association:—In following the splendid foundation laid by Mrs. Adcock, as well as all former presidents, we must go forward with ever increasing opportunities for Auxiliary accomplishments. To do this in one united effort, every member must be interested in the work and co-operate with her officers and chairmen, who are anxious and ready to assist all, in every way possible.

I take great pleasure in announcing the appointment of the following committee chairmen:

Parliamentarian	Mrs. D. F. Adeoek
Public Relations	
Hygeia	Mrs. E. O. Hentz
Membership	Mrs. J. W. Kitchin
Legislative	Mrs. H. L. Timmons
Legislative	
Bulletin	Mrs. James Gressette
Post-war Planning	Mrs. J. A. Seigling
Jane Todd Crawford	Mrs. J. H. Crooks
Publicity Secretary	Mrs. W. H. Folk
Corresponding Secretary	Mrs. J. D. Nelson

All Medical Auxiliary members should continue reading every issue of the national and South Carolina Bulletin and the Journal of the South Carolina Medical Association for important information of our work.

Your president is looking forward to working with you as an Auxiliary this coming year, and let us all remember our activities must be subordinate to the parent body, the Medical Association.

Mrs. P. M. Temples



Mrs. P. M. Temples, Spartanburg, S. C., President, Woman's Auxiliary to the South Carolina Medical Association 1948-1949

The twenty-third annual convention of the Woman's Auxiliary to the South Carolina Medical Association began its three day program on May 12 with various board and committee meetings. The convention proper began on the next morning with the meeting of the House of Delegates at nine-thirty. Mrs. David F. Adcock of Columbia, state president of the Auxiliary, presided. The program meeting followed at eleven O'cloek. Greetings were brought by Mrs. J. A. Seigling, president of the Charleston Auxiliary, and Mrs. Manly E. Hutchinson of Columbia responded.

Honor guests at the convention were Mrs. Eustacc A. Allen of Atlanta, president of the Woman's Auxiliary to the American Mcdical Association, and Mrs. Olin S. Cofer, also of Atlanta, president of the Woman's Auxiliary to the Southern Mcdical Association. Greetings were brought by Dr. Olin B. Chamberlain of Charleston, president of the South Carolina Mcdical Association. Dr. Robert B. Durham of Columbia, president-elect of the Association, was presented. At the conclusion of the program meeting Mrs. Adcock presented the gavel to Mrs. P. M. Temples of Spartanburg, who sueceeds her as president.

Dr. Walton Van Winkle, Jr., Secretary Therapeutic Trials Committee of the Division of Research and Therapy, American Medical Association, of Chieago, was the guest speaker at the luncheon held in the ball room of the Fort Sumter Hotel at one O'clock. Dr. Van Winkle's subject was "New Research Discoveries." Also present at the luncheon were members of the state advisory council, including Dr. T. A. Pitts of Columbia, Dr. Vance W. Brabham, Sr. of Orangeburg, and Mr. M. L. Meadors of Florence.

Entertainment for the afternoon was a walking tour

Entertainment for the afternoon was a walking tour of four old Charleston houses and one garden in the Church Street area, ending with a tea at the home of Mrs. W. Jervey Ravenel. These houses and the garden were opened as a special courtesy to convention guests.

Mrs. Olin B. Chamberlain was convention chairman and Mrs. I. Ripon Wilson was co-chairman. Miss Eloise Adcock of Columbia served her mother as president's page, assisted by Misses Elizabeth Speissegger and Joyce Taft of Charleston.

NEWS ITEMS

Dr. Albert B. Wolfe has announced the opening of his office in Orangeburg, his practice to be limited to surgery.

Dr. William Atmar Smith of Charleston was the principal speaker at the meeting of the Anderson County Tuberculosis Association in April.

Dr. Robert Pickens Marshall, a native of Greenwood, has won a \$1,500 fellowship to study socialized medicine in Sweden. The fellowship was received from the American-Scandinavian Foundation.

Dr. Robert Stanley and Dr. William Schulze of Greenville were the speakers at the May meeting of the Greenville County Medical Society. Dr. Stanley spoke on "Hypertension" and Dr. Schulze on "Indications for Spleenectomy."

The Edgewood Sanitarium, which was formerly in Aiken, has been moved to Orangeburg. Dr. Orin R. Yost has announced the association of Dr. Edward M. Burn in the practice of neurology and psychiatry.

GOLF TOURNAMENT

The American Medical Golfing Association will hold its 32nd Tournament on Monday, June 21. The beautiful Olympia Fields has been reserved for the medical golfers' tournament. Dinner will be served in the clubbouse and prizes will be awarded

the clubhouse and prizes will be awarded.

Olympia Fields Country Club has two eighteenhole courses which are ideal for experts and a treat for players with higher handicaps. Fellows may tee off between 7:30 a.m. and 2:00 p.m. Luncheon will be served at the Club. The Golfers' Banquet will be held at 7:00 p.m. Entertainment will follow the awarding of prizes.

of prizes.

The Chicago Tournament will give an opportunity to old and new Fellows to enjoy a wonderful day of golf, to win a nice prize, and to join in the famous Good-Fellowship of the American Medical Golfing Association. All male Fellows of the American Medical Association are cordially invited to become Fellows of the American Medical Golfing Association. Write to: Secretary Bill Burns, 2020 Olds Tower, Lansing 2, Michigan, for application blank.

Participants in the tournament are required to present their home club handicap, signed by the Club Secretary—or to accept a handicap set by the AMGA Handicap Committee. No handicap over 30 is allowed. All 18 hole trophies and prizes are awarded on the basis of scores for the first 18 holes played. A Fellow absent from the annual banquet following the tournament forfeits his rights to a trophy or prize.

Some 55 members of the Southeastern Society of Neurology and Psychiatry met at Edgewood Sanitarium in Orangeburg recently for the last meeting of the Society this season. The next meeting is scheduled to be held in Milledgeville, Ga., in September.

Dr. R. S. Matthews, chief of the Neuropsychiatric section of the Veterans' Administration Hospital, Fort Jackson, gave a paper on migraine headaches. Dr. Matthews told members of the society at this clinical meeting that two drugs are offering more and more help to sufferers from migraine headaches. He identified the two drugs as thiamine chloride and ergetamine tartrate. Dr. Matthews stated the latter drug has brought about the most dramatic resul?s. Both have been put into use in recent years in the treatment of migraine headaches.

The society re-elected as president, Dr. C. C. Odom, of the Veterans' Administration Hospital of Augusta, Ga., and Dr. Joe Freed of the South Carolina State Hospital, Columbia.

Dr. William J. Burdashaw of Augusta, Ga., was elected secretary-treasurer to succeed Dr. V. Frankfurth, also of Augusta.

Participating in the discussions on migraine headaches were Dr. W. R. Nead, Florence; Dr. F. E. Zemp, Columbia; and Dr. Coyt Ham, superintendent, South Carolina State Hospital, Columbia.

University of Pennsylvania Medical Alumni will hold a dinner at the Convention of the American Medical Association in Chicago, Wednesday, June 23, 1948 at the Lake Shore Club, 850 Lake Shore Drive. On arrival in Chicago, alumni should contact Miss Frances R. Houston, Executive Secretary of the Medical Alumni Society, at the University of Pennsylvania registration booth.

COLUMBIA, S. C. — A new concern to service artificial limbs opened in April in Columbia and will soon be in a position to manufacture artificial limbs. L. W. Bishop, director of the Research, Planning and Development Board of South Carolina, announced.

Development Board of South Carolina, announced.

The concern is a branch of the J. E. Hanger Company, of Atlanta, and will occupy offices and have repair facilities at 823 Main St., Columbia.

The Columbia office will carry a complete stock of goods and materials needed for repairs and will add personnel and equipment, as soon as possible, for the complete manufacture of artificial limbs.

J. E. Dillard, who will be in charge of the new branch and will direct the company's work in South Carolina, said he first contacted the American Legion in South Carolina for assistance in finding a suitable location and that the Legion directed him to the Research, Planning and Development Board. Decision to open a plant in South Carolina was reached when it was determined to provide quick service for residents of the State needing the company's services.

FOR SALE

Office equipment of the late Dr. Theodore Maddox, Union, S. C. For details, write Mrs. Theodore Maddox, Union, S. C.

The Iournal

of the

South Carolina Medical Association

VOLUME XLIV

July, 1948

Number 7

Minutes of Meeting of the House of Delegates

MAY 12, 1948

CHARLESTON, S. C.

(Centennial Meeting of the South Carolina Medical Association)

Presiding-Olin B. Chamberlain, M. D., President.

The Chair: We now open the Centennial Meeting of the South Carolina Medical Association.

DR. HOWARD STOKES: (Chairman, Credentials Committee) We have 52 authorized delegates.

The Chair: That is a quorum.

Gentlemen, the remarks of the president will be very short. We welcome you to Charleston. I not only have the opportunity of being the president this year but also a loyal Charlestonian and I hope very sincerely your meeting in Charleston will be one that will fill you with scientific food and a great deal of pleasure.

The Chair: We will now have the Report of Director of Public Relations and Counsel—Mr. Jack Meadors.

REPORT OF THE DIRECTOR OF PUBLIC RELATIONS AND COUNSEL

The past year has witnessed continued expansion in the activity and, we believe, in the effectiveness of the public relations department. The volume and variety of the tasks which have been undertaken exceeded that of past years, and so far as can be determined, the results have been satisfactory.

Committee of Eighteen

With the appointment of this Committee at the last annual meeting, and designation of your Director as its Executive Secretary, our office undertook the clerical work, and some of the administrative duties incident to the study of the State Board of Health. After the first full meeting of the Committee, we served with Dr. Chamberlain and Dr. F. G. Cain on a sub-committee authorized to procure the necessary professional services and proceed with the survey.

Mimeographed copies of the complete Mustard report were made in our office and furnished each member of the Committee. Later we were delegated the task of drafting the Committee's recommendations, in accordance with their expressions and decisions.

Legislation

Following closely upon the work of the Committee of Eighteen was the presentation of the results of its deliberations to the General Assembly. At the Committee's direction, a proposed Bill was drafted in our office, containing the provisions upon which the Committee had agreed, and following generally the recommendations of Dr. Mustard, but differing in some material respects therefrom.

We were constantly in touch with the matter from that point to the end of the legislative session, which was reached on April 15th. While the Bill was not introduced in the exact form drafted by the Committee, it was sufficiently similar to warrant the approval generally of the Committee of Eighteen, and of the members of Council.

One feature added by the Senate, however, which did not meet with the approval of the Committee and Council, would have established a Department of Health, under the general supervision of the Board of Health, but with considerable independence of operation from an executive and administrative standpoint. We therefore prepared an amendment to eliminate this section and took steps to have it introduced and supported. The Bill, however, was never reached for debate.

Since the whole idea and plan of the survey and proposed changes in the organization of the State Board of Health had been brought about through an effort to meet the demands of the Governor and some of the leaders in the Senate, and not through any desire on the part of the State Medical Association, there was no special effort made to push the Bill through, and failure of the Legislature to enact any new law on the subject was, we believe, entirely satisfactory to the Association.

Passage of the Medical Care Prepayment Plan enabling Act was completed with final reading in the Senate on March 18th, after a favorable report from the Scnate Committee on Medical Affairs had been secured. The Bill had been referred to that Committee last year, after passage by the House of Representatives, and favorable action by the Senate Committee was obtained only after some difficulty and a year's delay. The measure was passed just as introduced and without amendment by either legislative body. It became law upon its signature by the Governor on April 5th.

We assisted a Committee from the Board of Trustees of the Medical College in drafting a Bill, and subsequently in keeping in touch with its progress through the House and Senate, to establish scholarships at the College for the use of students who will agree to practice for stated periods in rural comminities. The Act was signed by the Governor on April 14th.

Our efforts with the proposed investigation of the Board of Naturopathic Examiners were not so successful. A Resolution identical with that which was passed by the House of Representatives last year, was introduced at the 1948 session and passed the House again without difficulty. In the Senate it was referred to the Medical Affairs Committee and immediately ran into trouble. The Naturopaths requested a Public Hearing, which was granted, and at the time fixed, the group was well represented. Despite considerable effort on our part to have present also a good representation of the doctors, only about three were on hand. The Naturopaths succeeded in convincing the Committee that they were equally anxious to correct any irregularities in their profession and, after two additional Hearings, the Medical Affairs Committee rewrote the proposed Resolution so as to provide for an investigation by the Board of Naturopathic Examiners, themselves, rather than by a joint legislative committee.

The revised Resolution was reported out and passed the Senate and the House on April 10th. This action was taken by the Senate Committee after hearing statements from Captain Legare Ansel, of the Office of Law Enforcement, concerning his investigation in the spring of 1947. The Committee appeared to be convinced, following his testimony, but when the Secretary of the Board of Naturopathic Examiners appeared again on the following day, the Committee concluded that the Board should be given an opportunity to clean its own house. The Resolution, as finally adopted, does take note of the irregularities in wholesale licensing of practitioners through reciprocity, with a State which has since outlawed the practice, and takes note also of the investigation prompted last year by the inquiry from the Connecticut State Department of Police. It directs the Board of Naturopathic Examiners to take the necessary steps and to report to the Legislature on its activities on the first day of the next session.

Auxiliary Bulletin

At the suggestion of Mrs. David F. Adcock, Presi-

dent of the Woman's Auxiliary, and with her fullest and splendid cooperation, the Bulletin, which is issued quarterly from our office, was made to serve a dual role as the organ of the Auxiliary. Under the present name of "The Auxiliary Bulletin", it serves to keep the members of the Auxiliary informed on the developments relating to public relations of the medical profession, and likewise as a medium for the communication by the Officers of the Auxiliary to their members of messages, reports and other items of interest. It is mimeographed in our office in Florence, usually containing about ten pages, and the most recent issue was sent within the past few days to a mailing list of 715. The members of the Auxiliary have expressed their thanks for this cooperation on the part of the State Medical Society, and we believe it has had a definite effect in stimulating interest on the part of the wives of the members of this Association. They have expressed approval of its format and general appearance, credit for the excellence of which is due our efficient office secretary, Mrs. H. W. Motte. It is in line with similar publications of the Auxiliaries to a number of other State Associations but is, we understand, the only publication of its kind in the South.

News Letter

In addition to the Bulletin, we have cooperated with Dr. Julian Price in the publication of several issues of a News Letter directed to the members of the Association. While some, though not all, of the material carried in the News Letter could be, and is published in the Journal, this serves as a means of quick information to the members on matters of importance, the interest of which would be adversely affected by the length of time which would have to elapse before it could appear in the Journal. No effort has been made so far to issue the News Letter regularly. Four numbers have appeared to date.

The Press

We found the press generally cooperative, particularly in connection with the Naturopathic investigation and news accounts concerning the annual meeting and the Health Conference just held. Mr. W. D. Workman of the News and Courier, and the Associated Press representatives have been particularly cooperative. While on this subject, attention should be called to the effort made to publish a series of articles on health. We had in mind, particularly, the weekly county publications. Experience of other State Medical Societies along this line, has indicated that the readers of the weekly papers, most of whom are in rural communities, appreciate the opportunity to obtain health suggestions through this medium, and are thereby made more aware of the interest of the doctors' organization, in maintaining the health of the people at the highest level possible. We were unable to go through with this plan, however, due to the fact that we were unable to obtain professional review of the articles which it was planned to publish. The members of the Committee to whom this was to have been referred, were too busy to undertake the effort this year. We trust that something of the sort can be worked out within the next few months, and believe that it will prove beneficial in the cultivation of our relations with the public.

South Carolina Physicians Committee

Your Director cooperated unofficially with a group of doctors who are interested individually, and not as members of the Association in creating the South Carolina Physicians Committee. This group, identified with the National Physicians Committee, has undertaken to raise funds from the doctors within the State to help finance the operation of the National organization. Our information, obtained at the meeting of the National Physicians Committee in Chicago last spring, indicates that this organization is doing effective work and that its methods and results are such as to justify financial support of the doctors who individually feel so inclined. It is not, however, and of course should not be, any part of the activity of the South Carolina Medical Association, as such.

Health Conference

Our office cooperated with Dr. Harold S. Gilmore, Chairman, and the members of his Committee on Rural Health, in the planning, organization and conduct of a statewide Health Conference at the Wade Hampton Hotel in Columbia on Thursday, May 6th. Splendid response was received from the 25 organizations invited to participate. The invitation was accepted by all except two, and the response from these indicated their interest and that they would have participated if previous engagements had not prevented.

The program arranged by Dr. Gilmore's Committee was planned with the view to eovering as completely as possible the whole scope of the health problem. Speakers were all prominent persons, well informed on their subjects, and the meeting appeared to be a decided success. Sponsored by the South Carolina Medical Association, which was host at lunchcon to those attending, the meeting concluded with a general discussion of the subjects presented and with an exploration of the need and plans for organization of a State Health Council. A steering committee of nine was appointed to pursue the idea further.

Chicago Meetings

The Conference of Secretaries and Editors of State Medical Associations was attended in Chicago in November, as were the Conferences on Rural Health in February of this year. The meetings were similar in general plan and discussion to those which are held each year. Nothing particularly new developed, but it is of real value and considerable importance to keep in touch through this medium with activities of the same nature as our own, in other states.

Richmond Conference

One of the most helpful meetings we have attended was a Conference in Richmond in December of last year, under the sponsorship of the Medical Society of Virginia, at which numbers of its members and prominent lay leaders in Virginia discussed various phases of the problems of furnishing medical care and maintaining health. On the day before this Conference, there was a meeting of the public relations representatives in the Southeastern States. We had the opportunity to discuss problems common to our section and methods of solution. The meeting was attended by Dr. Joseph Lawrence, of the Washington office of the A. M. A., and Mr. T. A. Hendricks, Secretary of the Council on Medical Service, from the Chicago office.

National Health Assembly

Although we are still too near the event to be able to clearly evaluate the significance, it is our impression that the National Health Assembly, called by the Federal Security Administrator, Mr. Oscar R. Ewing, and held at the Hotel Statler in Washington May 1st to 4th, was perhaps one of the most important events of the past ten years in connection with the subject of public health and medical practice. The stated purpose of the Conference was to explore the situation and develop a ten year national program. Approximately 800 delegates were invited and most of them were in attendance. While advance information was to the effect that accommodations would be limited and that perhaps representatives of the State Medical Societies would have difficulty in attending the sessions, this proved not to be the case. Your Director attended, as did many of the men employed in similar capacities by other State Associations.

There is no mistaking the trend. As we have had occasion to say before, the success of the leaders of the medical profession in shaping the course of the administration of medical eare in the United States in the future depends primarily upon the extent to which the doctors realize that their profession is a part of the American scene and will be dealt with accordingly. The medical profession will not receive favored treatment or more consideration than any other group, simply because its ideals and purposes are high and because it is devoted to the achievement of scientific perfection. It cannot escape the effect of the pull and tug of American politics, which affects every other profession and business.

The Exhibits

Turning now to the practical side, we handled again this year, the commercial exhibits and are glad to report a satisfactory return from that source. Due to the floor arrangement of the hotel here in Charleston, it was necessary for the exhibits to be scattered on no less than three levels. Despite this fact, we disposed of thirty-nine booths for a total of \$3,465.00,

which has been collected and is on deposit in the bank.

A luncheon was again planned for the representatives of the Exhibitors and the invitations were readily accepted. This gesture of friendship and cordiality seems to be appreciated by those who exhibit with us.

In this connection, let us keep in mind the importance of the exhibits from a financial standpoint and cooperate by visiting the displays whenever it is possible to do so. It is hoped that everyone attending the meeting will make it a point to visit each exhibit at least once and take sufficient time to discuss with the representatives some of the items on display.

Recommendations

In view of the developments so far in connection with our particular program, we make the following recommendations:

- 1. That the budget for the promotion of the Ten Point program be at least continued in the same amount as last year, and that enough room for expansion be allowed to permit the addition of certain additional projects, if and when approved by Council.
- 2. That the present Committee on Medical Service or a special committee be authorized to study, not simply a prepayment medical care plan along the line contemplated by the enabling Act just passed, but various systems of providing the lower income group of the population with insurance against the hazards of sickness and accidents. The type of prepayment plan referred to may be the best thing for South Carolina. On the other hand, there are other systems which are being used to advantage, and which results seem to indicate, in some instances, to be more desirable. We believe that before any definite action is taken to set up a separate prepayment plan, the feasibility of using the facilities of existing private insurance companies for underwriting of such risks should be carefully studied.
- 3. We believe that some organization in the respective districts should be worked out for the specific purpose of developing thought along the lines of the proper relationship between the medical profession and the public. One or two meetings in each district every year for the purpose of discussion of these particular problems alone, would go a long way toward developing the mental attitude which is necessary for the fullest cooperation of the members, generally, with this Department in its efforts to promote the program. We need more immediate and active cooperation in legislative matters. The district groups suggested might form the nucleus to provide the type of action which sometimes is absolutely necessary.
- 4. Finally, we would recommend that every member attempt to develop within his own mind, a completely realistic approach to the problems which con-

front us. The action of the Senate Committee in connection with the proposed Naturopathic Resolution was probably inconceivable to some members of the Association. That is because they have overlooked the fact that the average Legislator, the average Naturopath is a good citizen who has qualified for the practice of his particular branch of a legitimate healing art, has paid for the privilege of doing so, and has been licensed accordingly by the State. It also overlooks the fact that hundreds of people in South Carolina believe that they are being benefited by these practitioners, that these hundreds and their families and friends vote the same as do your families and friends, and that the members of the legislative body cannot be expected to have the same attitude as the doctors toward a situation with which they have not had oceasion to become familiar. This is merely an illustration. While, of course, there were one or two close friends of the Naturopaths on the Committee who had much to do with influencing the effort in this direction, it is our belief that the vote in this instance was the result of a conscientious feeling on the part of the Senators, that this was a fair and reasonable disposition of the matter.

The foregoing is only one instance of the need for realism in our approach to the problem of understanding the public's attitude toward the physician. We must first be willing and make an honest effort to understand the viewpoint of the public.

In conclusion, may we express our sincere thanks to Dr. Chamberlain, whose leadership throughout the year just ended, and whose kindly consideration in all matters in which we were called upon for assistance, has been a most pleasant and helpful experience. We would also express to Dr. Julian Price, Secretary, our thanks for his continued helpful suggestions and friendly cooperation at all times. To the members of Council, the Committee of Eighteen, to Dr. George Dean Johnson, Chairman of the Committee on Legislation and Public Policy, and to that particular group of physicians in every county upon whom we found so many occasions to call for help during the last legislative session, we wish to express our sincere gratitude for their response and for their very effective aid, without which the legislative program could not have been so successful.

Respectfully submitted,

M. L. Meadors

The Chair: You have heard his report, what disposition does the House Of Delegates wish to make?

Dr. Weston: I move that it be received as information. (Motion seconded by Dr. W. R. Wallace—there was no discussion,—the motion was voted on and unanimously passed and it was so ordered.)

The Chair: We will now hear the Report of the Secretary—Dr. J. P. Price.

REPORT OF THE SECRETARY

To the Members of the House of Delegates:

It is my privilege to submit to you a report of the work of our Association during the past year, and to make certain observations as to the future activities of our organization.

Membership

The total membership of our Association last year was 1012. Of this number 93 were Honorary Members.

Finances

The financial statement for the Association has been published in a recent issue of the Journal. From this it can be seen that our financial position is sound. Income exceeded expense in spite of the fact that we have increased our activities, allowing us to place an additional amount in our Reserve Fund. Our Reserve Fund now stands at \$14,000.00—ready to be used for any sudden emergency which might arise or to aid us in the day of recession, should it come. It is anticipated that our income this year will be sufficient to continue our present program and to bear the costs of publishing the history of our Association.

The Journal

Last year a questionnaire was sent to each member of the Association asking for an appraisal of the Journal and for suggestions as to its improvements. A summary of the findings was published last November. In line with suggestions made, the Clinical Pathological Conference is now appearing again each month, a special department of Abstracts is being maintained, and a new front cover has been adopted. It is hoped that these have met with favor. The Journal is now in a position to help authors materially with the cost of making cuts, and this has helped to liven up the appearance of the scientific section.

Securing good scientific articles is still a difficult problem and we wish to express our thanks to the members of the Editorial Board who have been of great assistance in this respect.

Particularly do we wish to thank Dr. R. M. Pollitzer for his series of articles on Historical Sidelights—which has been both scholarly and interesting—and Dr. J. I. Waring for his assistance in securing the Abstracts which are appearing each month. These two men have given unstintingly of their time and and ability.

News Letter

In line with another suggestion received through the questionnaire, we have instituted a News Letter which is being published and sent out at various intervals. We believe that this has fulfilled its purpose in bringing to the members of the Association important news on short notice, and in putting into brief form certain information which might be missed if presented in a routine manner in the Journal. We readily acknowledge that this News Letter has been an experiment, and we invite comments from this House of Delegates as to its value.

Automobile Emblems

Through the American Medical Association, special automobile emblems with the caduceus in the center and with "South Carolina Medical Association" around the periphery were made and sold to the members at cost. These met with general approval and approximately 400 of them were purchased and are to be seen upon the highroads of the state every day. We might add that we still have a few of these emblems on hand and they are still to be had at the original price of \$2.85. The manufacturers have assured us that if we order any more the cost will be increased fifty cents or more per emblem.

General Activities of The Association

In line with the general program of work as outlined in our Ten Point Program and with suggestions made by members in the returned questionnaires—to which reference has already been made—our Association has carried on its activities during the past year and concerning some of them we wish to make brief comment.

Cooperating with groups and individuals not in the medical profession. Your Association has continued to believe that one of our main functions was that of cooperating with any and all groups or individuals who were working for the best interests of the health and general welfare of the people of the state.

Our chosen representatives are serving on the Advisory Committee on Hospitals to the State Board of Health. Five of our members are serving as members of the Board of Directors of the South Carolina Hospital Service Plan (i. e. Blue Cross). Dr. George D. Johnson is acting as our representative on the South Carolina Committee on Children and Youth, and a member from our Association in the various counties is being asked to serve on sub-committees of this organization. Several of our members have been extremely active in the drive now being carried on to raise money with which to fight Cancer. A representative of our Association is a member of the South Carolina Nutrition Committee, Your Secretary is serving as Chairman, and Dr. Preston Edwards as a member, of a special sub-committee studying health services in our public schools, in connection with the survey now being conducted of our entire public school system.

The latest and probably most forward step which our Association has taken is in the promotion of the Conference on Health, recently held in Columbia. A full report of this Conference will be given by the Committee on Rural Health later this afternoon. However, at this time we would like to commend this Committee, of which Dr. Harold Gilmore is Chairman and Mr. Meadors is Executive Secretary, on the work which it has done and to urge that this House

of Delegates not only endorse but enthusiastically support the work which it has started.

Doing our part on the national level in formulating national policies. It is becoming more and more apparent that our Association is not only willing but anxious to assume its share of responsibility in making plans on the national level. We may be a small Association but we are fortunate in having a number of men who are clear thinkers and forceful speakers and these men have represented us well during the past year.

Dr. Chapman Milling served as our representative on the general committee of the Grass Roots Conference, sponsored by the American Medical Association, was elected chairman for the southern states district, and is scheduled as a speaker at the coming Conference in Chicago next month.

Dr. Harold Gilmore and Mr. M. L. Meadors represented us at the Annual Conference on Rural Health.

Dr. Charles Wyatt was our spokesman at the National Conference on Care of Veterans under the Veterans Administration and was appointed a member of a special committee of five to make recommendations to the Conference.

Dr. Harry F. Wilson represented our Association at the Annual Congress on Industrial Health.

Dr. Robert Durham, President-Elect of the Association, and your Secretary represented this Association at the Conference on Emergency Medical Service held recently in Chicago.

Mr. Meadors and your Secretary attended the annual Conference of State Medical Association Secretaries and Editors.

Last week, Mr. Meadors attended the National Health Conference in Washington as the official observer for our Association.

Dr. Hugh Smith continues to serve us as a delegate to the American Medical Association and is being recognized as one of the abler men in that body.

And, finally, Dr. W. L. (Buck) Pressly brought distinction upon himself and upon the Association by being the runner-up for the General Practitioner's Award presented last year by the American Medical Association. It is the hope of your Secretary that this House of Delegates will, today, nominate Dr. Pressly for this Award this year.

Educating the public as to what is needed in the broad field of medical care. When it comes to educating the public concerning medical affairs, the greatest single force is still the practicing physician talking to his private patient in his office, or to the patient in the clinic. A real physician is one who teaches as well as treats those who come under his care.

But this individual teaching, fine as it is, is not sufficient. A responsibility still rests upon our Association, as an organization of physicians, to assist in the education of the public in all matters which deal with medicine and medical affairs. Various methods of doing this have been tried with varying success. This House of Delegates is asked to pay special attention to the report of the Committee on Public Health and Instruction to be read this afternoon, as it presents a suggested plan for our work in this direction.

Making our advice available and influence felt in the halls and committee rooms of the General Assembly. The South Carolina Medical Association is not a political organization and we hope that it will never be. One of the responsibilities of our Association, however, is to make our advice available and our influence felt in legislative circles. As stated in our Constitution, two of our purposes are "to secure the enactment and enforcement of just medical laws", and "to enlighten and direct public opinion in regard to the great problems of medical care."

During the past year, our Association has endeavored to carry out these two purposes, and we invite your careful consideration to the reports presented by Mr. Meadors and by the Legislative Committee.

Association is held in high esteem by most of the members of the General Assembly and that our suggestions and opinions are given most careful consideration. Nowhere is this better illustrated than in the work of the special committee appointed by this House of Delegates last year to study the reorganization of the State Board of Health. Dr. Olin B. Chamberlain, Chairman of that Committee, will give the details of the story in his report.

Mr. Meadors, through his frequent visits to the General Assembly and through his many contacts with the legislators, has made many friends for the Association. His advice is sought concerning matters which deal with medicine, and he has been called upon more than once by some Senator or Representative to write a particular bill which deals with some medical subject—a bill which our Association has not promoted. We are convinced that it is not only to our interest but to the interests of the people of the state to have an individual such as Mr. Meadors to represent us before the lawmakers of the state.

Promoting plans for better medical care for our people. Four years ago, in our Ten Point Program, we outlined certain specific proposals for promoting better medical care for our people. Several of these proposals have become actualities; a Blue Cross plan is now in existence, a hospital survey has been made, funds for increased facilities for the Medical College have been provided, special scholarships for medical students have been established, a state health council is in the making, physicians have been located in needy areas. We would be the last to claim full credit for any of these accomplishments but we are

proud that they were a part of our original program and that we have had a share in their consummation.

Promoting Medical Service Plan for S. C. Finally after two years of effort, the General Assembly was persuaded to pass legislation allowing for the establishment of a Medical Service Plan in this state. Our Association is now faced with the decision as to whether such a plan should be established.

Preparing for the Cetchration of our Centennial. Considerable time has been spent by members of our Association in preparing for our Centennial celebration—and the result speaks for itself. Many have worked, but to two men and to one group of physicians must go the main credit for the meeting: Dr. Olin Chamberlain, President of the Association, has spared no effort in organizing the program; Dr. Joe Waring has not only spent long hours writing a history of the Association but has also served as General Chairman of Local Arrangements; the Charleston physicians, true to tradition, have assumed the role of hosts in a manner reminiscent of the Old South and the results, we are sure, would be satisfactory to their ancestors, the courtly old gentlemen who founded our Association one hundred years ago.

Emergency Medical Service. During the past few months it has become evident that every state should organize its resources so that they will be ready to function on short notice in the event of war. Since another war would undoubtedly be an atomic war, the demands of the civilian populace for medical care and advice would be greater than it has ever been before.

So far, no organization for furnishing emergency medical care and service for the civilian populace has been established in this state. It is our feeling that our Association should immediately take the lead in proposing the creation of such a body and should bend every effort toward lending its assistance in the building and perfecting of such an organization.

We would also urge that this Association make its position known to our representatives in Congress immediately with reference to the drafting of physicians up to the age of 45, as is now being proposed by the Military Affairs Committee of the House of Representatives.

Looking Ahead

As we step forward into the second century of our existence, it is only fitting that we should pause for a moment to study the road which lies ahead. In the distance, we see the goals toward which we are striving: a people whose standards of health are far better than they are today, a Medical College second to none, well-equipped and well-staffed hospitals adequate for the entire state, a health department reaching down to every part of every county carrying the message of healthful living, medical care available to all at a price which they can afford to pay, adequate provisions for the indigent and the

chronically ill, a group of physicians true to the high ideals of their profession practicing medicine in the free American way, and a world at peace.

But even as we gaze, clouds gather in the sky and dim our vision. Out of the east come the clouds which have plagued our peoples for the past hundreds of years-the three great foes of good health-ignorance, indifference and poverty. From another quarter come the clouds which have darkened the lives of many physicians and medical organizations—the love of money, indifference to the patient, and apathy toward the social and medical problems of the day. Out of the west, now advancing, now receding, yet ever ominous, comes the dark cloud which threatens the very existence of medical practice as we know it today—a government-controlled system of medical care. And in the north, shaped like a mushroom, hangs the darkest cloud of all-perhaps to be dispelled by a warm southern wind or to be churned into a mighty hurricane by a blast from the arctic regions—the threat of atomic war

The view which meets the eye, as we peer into the future, is one to sober and even discourage any thinking man. But it is not a new experience for members of our Association to see threatening clouds over the road to be travelled. Only a few years after our Association was founded, war swept across this state of ours leaving in its wake ruin and despair. Lesser men would have wilted under the pressure, but our forefathers in the profession—and in the flesh in many instances—did not know what it was to quit. The odds against them were great but their courage and determination was greater. And today we are celebrating the hundredth anniversary of our Association because these men were weighed in the balance and were not found wanting.

It behooves us then, in the spirit of those who have gone before, to dedicate ourselves, as individuals and as an Association, to the tasks which lie before us. We may not reach all the goals to which we aspire, but we will give to those who come after us the satisfaction and inspiration of knowing that, true to our heritage and to the noble traditions of our profession, we have lived and worked as real physicians.

JULIAN P. PRICE, Secretary.

The Chair: Gentlemen, you have heard the sobering and yet inspiring thoughts that have been engendered in our Secretary by the facts of the last year. I should like to put in a more or less personal word here. I must confess that up to a very few years ago I had little concept of the entire facade of organized medicine and of the increasingly important part that state organizations played in the part of the national organization. It was not until last year, as President-Elect of this organization, that I had the opportunity to visit national bodies and to really appreciate this fact. As to the "dark cloud" that Dr.

Price delineated, socialized medicine, the cloud is now overshadowing England, where on July 6th medicine will be socialized. In a poll 84% of the English physicians voted. 90% of the 84% voted they were not in favor of it. In spite of that it will become law. Such a thing may happen to us. There are many straws in the wind, many trends, trends pointing toward more powerful federalized control of our country. We are organized now, but we shall have to use that organization. It can't be done by the individual, it must be done by leadership in states and in sections of the country, who know that they have their physicians and colleagues behind them.

And, I speak with some pride, and I won't spare blushes, when I say it came to me as a matter of great gratification to find that our South Carolina, as small as it is, ranked very high in the councils, in the better councils of the Nation. To go to Chicago, myself, and to find that Dr. Julian Price was one of the best known men in organized medicine, of the kind of organized medicine that is going to have something to do with stopping socialized medicine; that Mr. Meadors was widely and favorably known; that our delegate Dr. Hugh Smith was a person who inspired confidence in others and had already, in the short time he was up there, made himself a strong position. I say that with pride, because I think again. just as British medicine has gone into something that God knows British medicine didn't want to go into, we are coming to the crossing of the ways and it is going to be necessary for us to realize this and support to the utmost these men whom we choose to represent us.

The Chair: At this moment I will read a greeting from the South Carolina Public Health Association.

May 6, 1948

Dr. Julian Price, Secretary South Carolina Medical Association Florence, South Carolina My dear Dr. Price:

The South Carolina Public Health Association sends greetings to the South Carolina State Medical Association in its Centennial Meeting.

A cordial invitation is extended to each member of the State Medical Association to attend the South Carolina Public Health Association Meeting at Myrtle Beach May 24-26. Dr. C. E. A. Winslow will be the speaker. Dr. Winslow is the former Director of the School of Public Health at Yale and a noted anthor.

Respectfully,

Laura Blackburn, R.N., President, South Carolina Public Health Association.

The Chair: Next we have the Report of Council—Dr. Roderick MacDonald.

REPORT OF COUNCIL

To the members of the House of Delegates: Your Council has continued its function this year of serving as the interim committee of this House of Delegates, as the financial committee for the Association, and as your agent responsible for the publication of the Journal.

During the year we have held meetings and the minutes of these have been published in the Journal.

We have studied the financial condition of our Association and find it to be in excellent condition. We have sufficient funds on hand to continue our present activities and to expand our work in the general field of public relations. In addition, our Reserve Fund now stands \$14,000.00.

The Journal has been published monthly and we believe that it is generally popular with the members. Advertising revenue has continued to be good and we believe that this condition will continue for the coming year.

Pursuant to instructions given by this House of Delegates last year we appointed the special committee to study the reorganization of the State Board of Health. We wish to commend Dr. Chamberlain, Chairman, and the entire committee for the business-like methods employed in their work. We suggest that the members of this body give special attention to the report of that committee when it is read this afternoon.

Your Council would like to comment upon the fine way in which Mr. M. L. Meadors handled the commercial exhibits last year at the annual meeting. The financial return was gratifying and prospects point toward several hunderd more dollars will be taken in this year, than last year. In view of this and of the increased amount of time that Mr. Meadors is giving to the Association and toward the publication of the bulletin of the Woman's Auxiliary, not to mention great increase in cost of living, your Council voted a bonus to Mr. Meadors for the current year.

This morning your Council met with representatives from the Woman's Auxiliary of our Association. Following a highly successful exchange of ideas, the following plan was agreed upon:

That the Association shall appropriate to the treasurer of the Woman's Auxiliary the sum of 50 cents per member of the association per year for the work of the Auxiliary, with the understanding that should additional funds be requested by the Auxiliary these will be considered by Council.

Your Council is deeply concerned with the necessity for preparation for any sudden international emergency which might arise. We do not anticipate a war but we want to be ready should a war come. We heard with mixed emotions the report brought back by our President-Elect and our Secretary from the recent national Conference on Emergency Medical Service. After careful consideration, we make the following recommendation: that the incoming president appoint a special committee to study the question and make recommendations to Council for further action.

Your Council heard Mr. James Ragsdale of the American. Mutual Liability Insurance Co., relative to a special mal-practice policy which his company is offering. After careful consideration your Council approved the policy as being sound, and will give a statement to that effect to the company. It is understood that this policy shall be sold only to members of the association. The Council wishes it clearly understood that it is not advocating the purchase of any particular type of insurance or any particular policy, but is merely carrying out its own policy of willingness to study any proposition presented to it by an ethical insurance company.

Believing that some form of recognition should be shown those members of our association who have practiced for 50 years, your Council is having made special lapel emblems to be presented to each one of these men in the near future, and we plan to make this a permanent feature. County secretaries are requested to notify our State Secretary of any who are eligible for this honor.

The Chair: You have heard the report of Council, with its recommendations. What is the pleasure of this assembly? There are no specific resolutions that have to be passed on. I should think it would be in order for the House of Delegates to approve the action of Council, and in some way express its approval or disapproval of its actions.

Dr. Milling: I move the adoption of this report. (The motion was seconded, there was no discussion, the motion was passed.)

The Chair: From now on, as you know, the reports are in the nature of Committee reports, some of those reports are long, some of the Chairmen will want to read them in detail, some they will wish to summarize. I will leave it to the individual judgment of each Chairman. Many of the reports have been mimeographed and will be handed out, as each Chairman makes his report in order that too much time may not be taken up.

I am going to appoint the Committee on Resolutions, and resolutions in these particular reports will be taken cognizance of by the Committee on Resolutions and will be reported to the House in their recommendations.

COMMITTE ON RESOLUTIONS-

Dr. William Weston—Chairman Dr. Carroll Brown Dr. T. G. Goldsmith

The Chair: The First Report is the Report of State Board of Health—Dr. W. R. Wallace, Chairman, Executive Committee.

REPORT OF CHAIRMAN OF THE STATE BOARD OF HEALTH

One hundred years of splendid achievement by the South Carolina Medical Association is the cause of much pride and satisfaction to every officer, every committee, and every individual member. The Executive Committee of the State Board of Health is especially grateful for the wise planning which brought it into being as a part of this association seventy years ago. So from the early years on up to the present time preventive medicine has been one of this associations chief concern.

From the vantage point of 1948 this association can look back upon a century of progress and development which cannot be equaled in any other field of endeavor. One by one many of the scourges of the previous centuries have given away to the relentless efforts of the medical profession. By the combined efforts of curative medicine, research and preventive medicine the span of life has been doubled during the life-time of this association. There are many from South Carolina who during this period working here in this state and elsewhere in the nation have brought honor and renown to the medical profession of our native state.

As we think about the past and look to the future we feel that every department of our organization should be reviewed to see if changes and improvements can be made. The members of the Executive Committee have thought for several years that certain amendments to the act of 1878, creating the Board of Health, should be made. They hesitated, however, to tamper with it fearing more harm than good would result.

After the Governor suggested lay representation on the Board and abolishing the ex officio members, your committee recommended to Council last year at Myrtle Beach three changes. Briefly they were to be (1) Stagger the election of members of the Board, (2) Shorten the term of office, and (3) Add two lay members. However, it was thought best to appoint a large committee of eighteen members to study the subject and recommend a bill to be introduced into legislature. Dr. Harry Mustard of New York, a native South Carolinian, was employed to make a professional study of our organization. We will have the pleasure of hearing a full report of the committee by President Olin Chamberlain a little later.

The proposed bill did not receive universal approval of legislature and several changes were made in the bill. These changes are mostly in our favor. It proposes that this association, as also the dental and pharmaceutical associations, can select their representatives and that the Governor will appoint those recommended by them. One nurse and a hospital administrator are to be added and are to be recommended by their respective associations. One citizen, appointed by the Governor, will make up the membership of the board. Legislature quickly restored the Pharmacist to the board which was not provided for by the bill proposed by the call meeting of the house of delegates. The bill after two readings in the Senate was placed in the hands of a committee set up by Legislature to study the reorganization of the state

government. The bill at its second reading called for six doctors, one druggist, one dentist, one nurse, one hospital administrator, and one layman, making an Executive Committee of eleven members as now constituted. The difference is that we lose one doctor and the two ex officio members. There will be added a nurse, a hospital administrator and one layman.

It is sincerely hoped that all can agree on all provisions of the bill and press for its passage next year. It seems at this time that this special committee will probably favor a bill in about the same form as the one left in the Senate. Next year the term of office of all members of the Executive Committee expire and if the bill passes before our annual meeting they can be selected according to the provisions therein set forth.

We regret to have to report to you the passing of Dr. D. Lesene Smith on July 7, 1947, who has served this association with distinction and honor as a member of the Executive Committee of the State Board of Health. His counsel and advice will be missed. The Governor appointed his son, Dr. Keitt H. Smith of Greenville to fill out his unexpired term.

Dr. F. L. Geiger, Director of the Division of Tuberculosis Control, resigned September 1, 1947. Dr. J. M. Preston, who has had much experience in the treatment of tuberculosis and who for several years had charge of the mobile unit clinics has been secured to fill this position. Also several of our County Health Officers, nurses and other personnel have entered other fields of work. The shortage of health officers, who must be trained medical men, remains acute. It has become necessary to give most of our health officers districts instead of counties.

The Hospital Construction Program has been fully organized and settled down to business. A full staff of competent, well trained men have been secured to assist Dr. Guyton, including an architect, a construction engineer, hospital administration consultant and an auditor. This is a cooperative program in which the Federal Government participates to the extent of one third of the cost of construction and equipment. Also under this act the hospital services are to be licensed and standardized, however, the effective date of this mandatory program has been advanced to about 1950. In this connection, I am sure it is a matter of satisfaction to know that an allocation was worked out for our College Hospital which will give this institution the necessary teaching facilities to remain a first class grade A school. The board has always felt that this was an important part of the program and we were glad to assist in having Federal Funds approved to the Medical College to the amount of \$1,550,000 to be paid over a three year period. The allocation of this money will affect the quotas and priorities of the counties very little if at all. It is hoped that construction cost will soon come down so that all localities where hospital facilities are sorely needed will qualify to participation in the fund provided by the Hill-Burton Act. The Advisory Council had done a great deal of work and has had several meetings with the Director, Dr. C. L. Guyton.

Each year our state becomes more and more industralized. We welcome these new enterprises as they give gainful employment for our people, add to the per capita wealth and increase the taxable property. However, health problems are increased. An act was passed at the recent session of legislature to appoint a committee representing various groups and interest to investigate and determine the proper and effective use of the fresh water resources of the state. The State Board of Health was asked to name some one from the engineering department to serve on this committee. Mr. W. T. Linton, Principal Sanitary Engineer, was recommended and was duly appointed by the Governor.

There are two types of crippled children, the epilepsy and cerebral palsy cases which we feel should receive some special carc and treatment. With the advances in scientific study of these conditions a more hopeful outlook is had for some of these unfortunates. Dr. Weston Cook who has had special training in one of the large medical centers where great numbers of palsy cases are treated will assist the Cripple Children Bureau in working out a program for this state.

In connection with the Cripple Children Program it is of considerable importance that an appropriation of \$18,000 was made by Legislature to assist the Orthopedic Camp for Crippled Children held at Poinsett Park in Sumter County. The camp is divided into four periods of two weeks each and approximately one hundred children will have the opportunity of attending each session.

For many years we have had a very advantageous contract with a large manufacturing concern to furnish most of the biological use in public health work and those furnished to the doctors. Changes in conditions, policies, and prices have rendered this connection unsatisfactory. We will soon begin to distribute these products with our own facilities after purchasing them on competitive bids as needed. General hospitals can now act as depositories for diptheria antitoxins instead of drug stores which seem to be more satisfactory to the practicing physicians.

On the 14th of April 1948 the Governor approved "An Act To Establish Scholarships For Students At The Medical College Of South Carolina." This act provides eight scholarships at the medical college with tuition and \$75.00 per month stipend. The recipient of such scholarship is required to enter into a contract that he or she will do private and general practice during one calendar year for each school year, in a rural community to be designated by the State Board of Health of South Carolina, or in lieu thereof, shall practice in a State Medical Institution

designated by the State Board of Health. The act makes it the duty of the Board of Health to designate such rural areas.

There are two other bills that were passed by recent legislature that I wish to mention. One is to provide for the commitment to Sanatoria of persons suffering from active pulmonary tuberculosis. This regulation has been needed for a long while. It provides that after a diagnosis of pulmonary tuberculosis is made and the patient refuses to take such measures as to prevent him from being a menace to others, the County Health Officer shall lodge a complaint with the Judge of Probate of the county concerned. If the Judge of Probate, after due notice and hearing is satisfied that the complaint is well founded, he may eommit the person concerned either to the State or County Sanatorium. If the patient leaves the Sanatorium or conducts himself in such a way as to ieopardize the well being of his fellow patient, he may be isolated or forcibly detained.

Also, the legislature brought up to date an act governing the manufacturing or renovating of mattresses. The intent of this act being to allow the sale or use of mattresses which are free from danger to the purchaser.

A very distinct honor came to a member of our Board this year when Dr. W. L. Pressley of Due West was chosen by the American Association as one of the outstanding general practitioners of this nation. He missed first place by only a few votes.

Dr. James A. Hayne, long the State Health Officer, severed his official connection with the Board of Health on June 30, 1947 under the State Retirement Act. We were glad to secure his services for the United States Government on a part time basis as consultant on the control of communicable diseases.

In the interest of rural health and sanitation, Drs. A. W. Browning and J. I. Waring were sent to Chicago to attend a national conference. We felt that the importance of this matter and the valuable information obtained was well worth the expense.

The legislature this year provided for the legal distribution of Federal and State funds to the County Health Departments. The distribution formula is based on population, with some significance placed on financial ability of the county, and numerous specific health problems, such as maternal and child health, tuberculosis, venereal diseases, etc. These funds with a flat grant make up the distribution.

It was the decision of the Board that patients hospitalized under the Cripple Children Program should have the benefit of expert medical care as well as expert surgical attention. To carry out this phase of the work the State Health Officer was instructed to arrange for competent pediatric examination and supervision while in the hospital so as to return the

case to its home in the very best physical condition possible.

Legislature evidenced its confidence in the State Board of Health again this year by a reasonable liberality in its appropriations. A total sum of \$1,800,000 was provided for all health projects including the operation of the South Carolina Sanatorium. Approximately \$275,000 was made available for D.D.T. control of malaria. This control is to be on a state-wide basis, but is only available to sections where anophelene mosquitoes can be identified.

We will not attempt to review with you the progress made in many of the projects mentioned in previous reports. For complete details of these and many other matters of interest from the standpoint of Public Health we refer you to the Annual Report which will soon be off the press. We wish to thank each of you for your interest, your cooperation, and your constructive criticisms.

Respectfully submitted,

W. R. Wallace Chairman of the Executive Committee of the State Board of Health

The Chair: I am afraid there are many of us who do not realize the amount of hard work and labor that goes with the sort of job that Dr. Wallace and other members of the State Board of Health have done.

The next report is that of Dr. Hugh Smith, Report of the Delegate to the American Medical Association.

The Interim Meeting of the House of Delegates of the American Medical Association on January 5 and 6, followed by the first mid-winter meeting for General Practitioners on the 7 and 8, was held in Cleveland as planned. The attendance of this first mid-year meeting for General Practitioners was probably very good, there being some 3500 registrants. Naturally a large portion of these were from Cleveland and Ohio and nearby states. The program was an excellent one, with well arranged symposia on subjects of general interest. The speakers were noted American physicians, most of them teachers and outstanding clinicians, famous in some special field. The meetings were in a large auditorium with good acoustics. The subjects were dealt with in order, with a question and answer period after each symposium. Then a brief intermission to enable visitors to view the exhibits, both commercial and scientific, followed. The program was well organized and expertly managed. My only doubt after attending one such meeting, is that it will actually serve any really useful purpose that a well organized State Medical Meeting does not already do as well. Perhaps we should not judge too quickly the success of this mid-year meeting for General Practitioners.

One of the most informative and interesting events at this meeting was the National Conference of

County Medical Society Officers. This occurred the evening of January 6. Here were perhaps three hundred medical men who brought into discussion the real problems of the General Practitioner, such as hospital facilities and proper recognition of his abilities to do, for instance, tonsillectomies, simple fractures, uncomplicated obstetrics, etc. In many communities hospital appointments and beds are apparently not available to general men, and they are perforce required to refer their cases that need hospital care to men, usually specialists, with hospital staff appointments.

The House of Delegates met for two days and completed its work with unusual despatch. A committee to expedite work of the House was appointed last June and brought its report to this meeting. The changes are not dramatic but do call for certain changes, limitations and deletions that should improve the meetings. This report was approved and followed at this meeting. I think it will actually expedite the meetings of the House of Delegates.

The first order of business on Monday morning was the nomination and election of the General Practice Award, We, in South Carolina, have every right to be proud of the fact that our Buck Pressly was one of the three outstanding men selected by the Board of Trustees, one of whom was to be elected for the Award by the House of Delegates. The Chairman of the Board of Trustees read brief sketches about these three men and without further discussion or any personal eulogies the House was asked to vote for the award. The winner, Dr. Archie Sudan of Denver, Colorado, was presented the gold medal on Wednesday night at a public meeting. At this meeting the Honorable Clinton P. Anderson, Secretary Agriculture, delivered a splendid address. Following him the Award to Dr. Sudan was presented. As your Delegate I am sorry that Dr. Pressly did not win, and proud that he was runner-up in the final vote. It is my hope, and my suggestion, that we again nominate Buck for this great honor and present his name for this award next year.

Dr. Edward L. Bortz, President of the American Medical Association, made an excellent talk to the House. One of his suggestions was to encourage medical undergraduates to participate in organized medicine. He thought medical students and interns should attend County and State Meetings and that they should be instructed all along about medical and economic problems and encouraged to seek early affiliation with organized medicine. Dr. Bortz paid great praise to the medical auxiliary. His idea, and a sound one indeed, is that they are perhaps our most effective public relations experts and that accordingly they should be kept informed of various issues confronting our profession.

Dr. Ehmer Henderson, Chairman of the Board of Trustees, made the report for the Board. We were informed that as a result of the great increase in all costs of operation the American Medical Association lost one hundred and seventy thousand dollars in 1947, and that with all possible retrenchments a deficit of one hundred thousand dollars for 1948 seems apparent. In view of this report of our serious financial status, the House of Delegates voted to increase Fellowship dues to twelve dollars annually which of course includes the subscription price of the Journal of the American Medical Association. This increase from eight to twelve dollars should increase our revenue to meet all expected expenses and keep the A.M.A. out of the red.

Dr. Henderson also reported on the meeting in Paris last fall to organize the World Medical Association. In September, 1947 our association agreed to subscribe fifty thousand dollars a year for five years with certain provisions, the most important one being that the Headquarters of this new organization must be in the United States where it can be free in fact. New York City was selected for this purpose. The German Medical Profession was not invited nor allowed to affiliate until they have condemned the horrible war practices of the recent Hitler regime and until they have regained the confidence and esteem of the Medical Profession of the World again. The purpose of the International Medical Association is to further International good will and better medicine.

The House of Delegates requested the appointment of a special committee of five, including two general practitioners, to study intern placing and adequate rotation plans in hospital training programs. This eommittee is to cooperate with the Council on Medical Education and hospitals and report its findings and recommendations at the annual meeting next June in Chicago. This may well become an important problem as we are rapidly returning to a normal number of medical graduates each year and there may soon develop a situation where there will be more approved internships and residencies than candidates. An equitable distribution would then indeed be important.

In the Journal of the American Medical Association for January 17, 1948, Volume 136, No. 3, pages 181 to 191, is a comprehensive report of this recent meeting of the House of Delegates. Here one may read briefly about all resolutions and discussions and readily familiarize himself with the work done in Cleveland. The report on association finances will answer your questions as to the increased cost of your Journal. The report on Hospitals and Practice of Medicine is informative. The report of the Committee on Nursing Problems is presented. It is only a progress report but indicates serious consideration of this problem.

I would recommend to very member of our State Association a careful reading of this report.

> Respectfully, Hugh Smith, M.D. Delegate for South Carolina

The Chair: We will now hear the Report of Rural Health Committee—Dr. Harold Gilmore.

REPORT OF THE COMMITTEE ON RURAL HEALTH OF THE SOUTH CAROLINA MEDICAL ASSOCIATION

A few weeks after the annual meeting of the South Carolina Medical Association last year, the undersigned was appointed Chairman of the Committee on Rural Health for the Association. This was the first Committee on Rural Health ever appointed by the State Association and for some months I floundered around trying to find out what it was all about.

In November, 1947, I attended the Southeastern Regional Conference on Rural Health, in Atlanta. There I was enlightened as to the great needs for better health conditions in the rural areas of the United States. It was elearly pointed out by prominent laymen and physicians that in the vast proportion of our rural areas there was a tremendous shortage of doctors, nurses, and hospital and health center facilities.

The Federal government was trying to remedy some of the shortages by helping finance hospitals and health centers through the Hill-Burton Bill. Some states were trying to relieve the rural doctor shortage by giving scholarships to Medical schools whereby the recipient of these scholarships would later praetice for a designated period of time in a rural area. Then some local communities were taking the problem into their own hands and making it attractive for young doctors and dentists to locate in these rural or semi-rural areas.

The up-shot of most of the trouble seems to lie in the fact that there are too few doctors graduating from medical schools and still fewer locating in rural areas.

Then, there is the eternal economic situation. For if a community whose economic condition is so poor as not to be able to support a physician financially, then, that community will continue to lack for the services of a physician unless they find one who is missionary-minded or unless one is subsidized by the state or federal government.

In February, 1948, I attended the National Conference on Health in Chicago. The theme of this conference was: Better Rural Child Health—which in the long run means better rural health in general. Here, too, was pointed out the shortages of doctors, dentists, nurses, and hospital facilities in the rural communities. (Report on this conference in April, 1948 issue of the Journal of the South Carolina Medical Association, page 133).

What impressed me so greatly at this conference was the fact that the rural people—represented by big rural organizations such as: The Farm Grange, Milk

Producers Association, American Farm Bureau Federation, Farmers Educational and Cooperative Union of America, etc.—knew what they wanted and seemed to be determined to get it in one way or the other, either by a government plan or an acceptable plan from the medical profession.

When it is pointed out that one-third of the population, eomprising 13 million children, are in rural areas; that they are served by 24% of hospital beds, 21% of physicians and 19% of the dentists, it is reasonable to see why these farm folk are so concerned over the health problems of the nation.

Having gained some information and a better perspective as to what might be done for better rural health in South Carolina as a result of attending these conferences, the Chairman and his Committee consisting of: Drs. A. W. Browning, M. H. Boggs, and James A. Hayne, Jr., with Dr. Julian Price and Mr. M. L. Meadors acting in an advisory capacity, a statewide health conference was called to meet in Columbia, May 6, 1948.

At this conference 57 were present, representing 23 state-wide organizations and state departments interested in health. Besides the medical, pharmaeeutical, and nurses group, other groups included the Farm Grange, Tuberculosis Association, Cancer Society, Federation of Labor, State Chamber of Commerce, etc. A well-balanced program was presented consisting of speakers from Industry, Agriculture, Medicine, Education, and State Health Department. Following this program a round table discussion was held which brought out some significant points regarding the health situation and the health needs of the state.

A report from the Resolutions Committee, which was appointed in the earlier part of the conference, was unanimous for the formation of a permanent State Health Council and the formation of County Health Councils. They also appointed a Steering Committee to set in motion the machinery for the establishment of a permanent Health Council. The Committee consists of Dr. H. S. Gilmore, Nichols, S. C., Chairman; Mr. M. L. Meadors, Florence, S. C., Secretary; Mr. W. W. Lowrence, Sumter, S. C.; Mr. E. M. Goldsmith, Greenville, S. C.; Mr. O. G. Dorn, Sumter, S. C.; Mr. R. C. Edwards, Abbeville, S. C.; Dr. C. L. Guyton, Columbia, S. C.; Miss Katherine Ewards, Columbia, S. C., and Miss Jane Ketchin, Rock Hill, S. C.

It was agreed that the Steering Committee would meet in the near future and make plans for another state-wide conference in the fall, at which time a permanent council would be duly set up.

I was amazed at the cooperation, interest, and enthusiasm exhibited by this group for the establishment of a permanent State Health Council. The Committee feels that such a council would be of inestimable value in bringing the various organizations of the State, interested in health, together to discuss and work out their mutual problems and to correlate their efforts toward bringing about better health for the people of the State. We think that this is not only a very progressive step for the South Carolina Medical Association but a history-making one for the Association for better health in South Carolina.

In the interest of better rural health in South Carolina, the Committee on Rural Health recommends the following:

- I. Formation of a State Health Council and a County Health Council in each County of the State, sponsored by the local county Medical Society.
- II. That scholarships to the South Carolina Medical College be given to worthy students who will go to rural areas to practice.

III. To develop faculty teams at the Medical College to give post-graduate courses over the state directed particularly at the general practitioner.

IV. To study the advisability and practicability of placing senior medical students or senior internes under the preceptorship of qualified physicians in the rural or semi-rural areas of the state for a limited time.

Respectfully submitted by the Committee on Rural Health.

II. S. Gilmore, M.D., ChairmanA. W. Browning, M.D.M. H. Boggs, M.D.James A. Hayne, Jr., M.D.

The Chair: The association is appreciative of the splendid work you and your Committee have done. There were some special recommendations made and I hope the Committee on Resolutions have taken special note of them.

Report of State Board of Medical Examiners—Dr. N. B. Heyward.

REPORT OF STATE BOARD OF MEDICAL EXAMINERS FOR 1947

Licenses issued after written examinations	55
Lieenses issued by reciprocity	40
Total	95
Applicants failing after written examination Applicants from Grade B & Foreign schools	
refused	Many
Receipts from activities of Board	\$3,785.00
Expenses of Board	2,740.46
Profit to State of S. C.	\$1,044.54

By invitation, the Board became a member of The Federation of State Medical Boards of the United States.

Reciprocities for 1946 55 Reciprocities for 1947 40

Total 95 for last two years

During the emergency, a great many Grade B men were taken in mostly in the hospitals, taken in with the sanction of the American Medical Association, providing the hospital had a majority of the other, rather than Grade B. These men were liked, they were treated well, they wanted to stay. At Summerville a man was working, he was well-liked, and Dr. Tucker took him up, he assumed practicing all over the county. He wanted to be licensed in South Carolina, he graduated from some hospital school but was a pretty good boy. The first thing we knew an Act was passed through the Senate by J. D. Palmer, he had passed it clean through the Senate, instructing the Board of Medical Examiners to examine him and issue him a license. We caught it in time, got it into the House and stopped it.

We have in Columbia two Grade B men, one is now, a pretty good boy, pushing now to make us license him. One man in the up-country that did good work up there; a good man in the Pee Dec. doing good work; and these men all trying to get into the State Association. We have By-Laws and Regulations for the Board, and the Act gives us power to make rules and regulations, and these are law, as far as this Board is concerned, and as far as the legislature is concerned. These were not formed off-hand, most of them are the result of bitter experience. When I first came on the Board some years ago, Dr. Dibble is the only man who has been on the Board longer than I have, Dr. von Bowman from the University of Heidelberg eame with a most gorgeous diploma. The Board examined and admired it excessively, a marvelous thing, they had never seen one before and the doctor was shown special eonsideration and he was lieensed. He had paid \$25.00 for the diploma in St. Louis. We are shy of foreign diplomas.

One came up with the University of London, we went into that, verified it by cable, we licensed him, we are still suffering. He was a bad one too.

From then on the rule of the Board was "no foreign diplomas". We tried to get the AMA to rule on them, they say they ean't rule on them, they only can pass on the ones they can inspect and it is up to the individual board to pass on them before. I have a letter from the AMA recently telling me that.

We had a man come in from the University of Vienna, we made him come to Charleston and told him we could take him if he would come to Charleston and spend a year in Charleston. He evidently came up to grade, he was graduated from Charleston and he took our Board and passed it and he is a valuable member of the Association today. We advised all others with foreign diplomas to do that.

Evidently the position we have taken in the matter has been noised abroad. I have a letter from the State Board of Medical Examiners of Colorado stating "information from the AMA indicated a non-acceptance of foreign graduates is the policy of your board. Would you kindly advise us if your policy of nonaeeeptance of foreign graduates is by statutory law or by resolution of your Board. All of this is desired to guide us in formulation of our future policy, beeause of the high regard this Board has for the functioning of your Board."

According to The Research Planning and Development Board, the percentage of doctors in South Carolina is about one doctor to every 1600 people. The ideal to which everyone strives is about one doctor to every 1000 people. We are not so bad down here, right now, that we have to let the bars down. We have many of our own boys still in service, many are taking refresher courses, many, I hear that want reciprocity. Those boys will be coming home before long, we are not hard enough up to flood our state with undesirables.

We have been pushed pretty hard on some of these boys, people particularly interested in them, they can see their good points and they are particularly anxious to have them in the State and have the Board accept them and the Board has refused consistently and we will continue to refuse unless the House of Delegates orders otherwise.

We would like the house to express an opinion and sanction or condemn us. We are here representing you. It is your Medical Association; we are representing and are doing your work. If you disapprove our policy, trying to keep out low-grade men, we would like to ask some motion or expression be given by the House of Delegates as to what course you would like us to take.

(Applause)

The Chair: In relation to Dr. Heyward's report I shall read at this time a communication received from the South Carolina Chapter of General Practice.

"The South Carolina Chapter of General Praetice assembled here the 12th of May, 1948, wishes to commend the State Board of Medical Examiners on their practice of licensing *only* graduates of Class A Medical Schools, and urges that this practice be continued.

Signed—Charles N. Wyatt, Secretary."

Also, in this connection, I should like to read a resolution passed by council this morning.

RESOLUTION

"WHEREAS:

- (1) There appears to be a concerted effort on the part of some groups to break down the standards for obtaining a license to practice in South Carolina in order to admit persons holding diplomas from Grade B and Foreign medical schools, and
- (2) The Examining Board has been flooded with applications for license by Refugees with foreign diplomas and by holders of diplomas from Grade B and ungraded schools, and
- (3) The present Board is insisting that these standards be strictly adhered to in order to keep the

Profession of the State up to its present high level and to keep open the available vacancies for our own young Doctors, at present in the Army or Navy or in refresher courses over the country;

"THEREFORE BE IT RESOLVED;

That Council go on record as eommending the rules and by-laws of the S. C. Board of Medieal Examiners and expressing confidence in the judgment of the Board."

Following the usual procedure, I shall ask the Committee on Resolutions to consider the resolutions advanced by Dr. Heyward, and at a suitable time to bring in their resolution.

Dr. Pitts: I presume all of the members of the medical profession are from time to time asked to use their influence or to request them to try to get certain persons a special license. I have nothing to do with the Board of Medical Examiners but only recently, within the week a typical example has happened, from a very high person in the Government, a United States Senator.

(Dr. Pitts reads a letter from Senator Olin D. Johnson.)

I have nothing to say against Olin Johnson in this matter. He was probably urged to do something and this is what he has done. This answer is a copy of the letter I wrote Senator Johnson, which I think sums up how I feel about this thing. (Answer is read)

Motion—Dr. Tom Pitts: I would like to move you, sir, that the House of Delegates go on record commending the Board of Medical Examiners in their stand and to let them feel that we are thoroughly in accord with what they are doing. (The motion is seconded.)

The Chair: It has been moved and seconded that the Board of Medical Examiners be informed that we, the House of Delegates, are thoroughly in accord with their position in the matter which has been so well outlined. Is there any discussion?

Hearing none, I put the question. All in favor signify by saying "Aye" (There were many ayes.) All opposed signify by saying "no". (There were no "noes") It is a unanimous vote.

I have here a telegram from the Greenville Retail Drug Association, per John S. Ashmore "Wishing you a very successful and constructive convention."

Gentlemen, most of the remaining reports are mimeographed and at this time I will ask that they be passed out to you.

(Three Minutes Recess Period)

The Chair: The next order of business is the Report of the Cancer Control Commission—Dr. J. R. Young.

REPORT OF THE CANCER COMMISSION

The Cancer Committee of the South Carolina Medical Association, the Cancer Commission of our State Board of Health, and the Executive Committee of the South Carolina Cancer Society have had

(Con't. on p. 244)

THEY ANSWERED THE FINAL CALL OF THE GREAT PHYSICIAN

The solemn moment of the Centennial Meeting of our Association was the reading of the report of the Memorial Committee. As the members stood with bowed heads, the Chairman of the Committee, Dr. W. Atmar Smith, ealled the roll of those who had gone to their reward during the past year.

Able, C. 11.	Norway	March 29, 1948
Barksdale, I. S.	Greenville	Feb. 10, 1948
Blitch, Joseph J.	Yonges Island	Oct. 14, 1947
Brown, Arthur H.	Oswego	Mareh 6, 1948
Burgess, William S.	Sumter	Jan. 31, 1948
Cudd, J. E.	Spartanburg	Nov. 14, 1947
Davis, Thomas L.	Abbeville	Oet. 2, 1947
DesPortes, James R.	Fort Mill	June 2, 1947
Garrett, James F.	Greenville	Oct. 3, 1947
Green, Dove Walter	Conway	Jan. 16, 1948
Guerry, LeGrande	Columbia	Aug. 14, 1947
Hicks, William E.	Sardis	Feb. 8, 1948
James, Frederick G.	Greer	June 26, 1947
Kennedy, George L.	Ninety Six	Jan. 12, 1948
Kirby, Joe H.	Loris	May 16, 1947
Littlejohn, Thomas R.	Sumter	July 26, 1947
Maddox, Theodore	Union	Mareh 12, 1948
MeLeod, James C.	Florence	Dec. 9, 1947
Moore, Samuel B.	Tueapau	June 28, 1947
Nelson, Manning L.	North	Feb. 21, 1948
Pate, Charles H.	Scranton	June 28, 1947
Pettus, William J.	Charleston	Dec. 28, 1947
Robinson, Lewis Franklin	Greenville	June 21, 1947
Rodgers, Floyd D.	State Park	Nov. 7, 1947
Roof, G. M. S.	Columbia	Sept. 7, 1947
Simpson, Furman T.	Westminster	Jan. 29, 1948
Smith, D. Lesesne	Spartanburg	July 7, 1947
Stewart, Henry Boardman	Fairview Community	Sept. 15, 1947
Thomson, M. A.	Anderson	Mareh 22, 1948
Thompson, Wade	Anderson	Aug. 23, 1947
Wansley, W. B.	Iva	Jan. 5, 1948

The Journal of the South Carolina Medical Association

EDITOR: Julian P. Price		Florence, S. C.		
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Please send in promptly notice of change of address, giving both old and new; always state whether the change is temporary or permanent. Original manuscripts, subject to approval by the Editor and the Editorial Board, are desired for publication in the Journal. They should be typewritten, double spaced, on $8\frac{1}{2} \times 11$ paper. References should be complete, and only such as relate directly to statements quoted in the paper. Illustrations will be used as funds permit, or as authors are willing to bear the necessary increase in cost. Short original articles are preferred to long reviews.

Office of Publication: (In care of the Editor) Florence, S. C. Subscription Price \$3.00 per Year

JULY, 1948

C. FRED WILLIAMS

In the passing of Dr. C. Fred Williams, South Carolina lost one of her distinguished sons and our Association lost one of her most honored leaders and beloved members.

Each man in his own way builds his own memorial before he dies. This was true of Fred Williams. Fred Williams has gone to his reward, but in his wake he has left two monuments by which he will ever be remembered.

The first monument stands in Columbia—the State Hospital. Thirty-three years ago, following a term as State Health Officer, Fred Williams was establishing a practice in Columbia, and was doing well. Suddenly, he was offered the Superintendency of the State Hospital. He did not seek the job and did not want it when it was first tendered to him. But as he told his friends, "I felt it was a call to duty I could not ignore." After careful and prayerful consideration, he assumed the responsibility. Through the years he struggled and planned and toiled. At times the burden seemed too much for any man to bear, but Fred Williams did not know what it was to quit. Today the institution is recognized as one of the best in the land.

The second monument which exists today to remind us of Fred Williams is the memory of the Christian life which he lived. He loved his church and worked for it. One of the projects nearest his heart in his later years was the raising of money for the erection of a church edifice on the hospital grounds. He saw beyond the bodies and minds of people, he was concerned with their souls. He loved the Great Physician and, to the best of his ability, walked in His footsteps.

Fred Williams has gone but the seventy-one years he spent upon this earth have made South Carolina a better place in which to live. And those of us who were privileged to call him colleague and friend, have lost a comrade whose very presence made life a little finer and a little nobler.

THE CANDIDATES SPEAK

The South Carolina Medical Association is not a political organization. Each of our members, however, is a citizen and a voter and as such is entitled to know the beliefs and opinions of those who are seeking political office. Particularly is he desirous of knowing their stand upon questions dealing with the broad field of medical eare.

With this in mind, we sent a letter to each one of the aspirants for the office of United States Senator, asking specific questions and offering the columns of the Journal for publication of the answers and for other comments which might be made.

We take pleasure herewith in presenting the letter and the replies which have been received:

"In view of the current widespread interest in measures pending in Congress designed to create a system of medical care financed and administered by the Federal Government, the physicians of South Carolina, naturally, would like to know the views which you, as a candidate for the U. S. Senate, may hold on this and related subjects.

"We would like to extend to you the privilege of using the columns of the Journal of the Association for an expression by you on any or all of the questions stated below. The Journal is mailed each month to approximately 1100 doctors and others in South Carolina. The same courtesy was extended to candidates for the Senate two years ago, and a copy of this letter is being sent to all the announced candidates this year.

- "1. Are you in favor of compulsory Health Insurance, financed with public funds, as proposed under the terms of the Wagner-Murray-Dingell Bill?
- "2. Do you believe that medical service can best be rendered through a system of private practice such as now exists in the United States, or through a system financed and administered by Government?
- "3. Do you think that Federal aid for health, rehabilitation and medical service should be extended through facilities of the states, or directly through a Department of the central government?

"Replies received from any of the candidates by June 20th will be published in whole or in part in the July issue of the Association Journal.

> Sincerely yours, Julian P. Price, M.D. Secretary-Editor."

June 15, 1948

Dr. Julian P. Price Secretary-Editor South Carolina Medical Association Florence, S. C.

Dear Dr. Price:

I appreciate very much your kind offer of the columns of the Medical Association Journal. I am glad of the opportunity to inform the Doctors of South Carolina as to my convictions on these important questions.

My statement follows:

Karl Marx, the founder of communism, is reputed to have said that the first step toward communism is socialism. Communism is socialism incomplete. The Congressional Committee on Expenditures in the Executive Departments, upon which I serve, found out in an investigation last year that the movement for socialized medicine in America originated largely with the communists. That much of the cost of propaganda for this movement was spent by the Federal Government out of funds appropriated for Public Health Aid, et. Copies of this report may be obtained upon request.

In answering the submitted questions, I do so with an open mind for the welfare of all the people, now and in the future. I favor doing all that is necessary to adequately provide for the medical care of our people which is consistent with our concept of free initiative and enterprise.

- 1. I am opposed to financing with public funds the cost of any compulsory Health Insurance program, as provided for in the Wagner-Murray-Dingell bill. Such program if enacted into law, would be a substantial step toward socialized medicine.
- 2. I am unalterably opposed to socialized medicine or any system of medical service financed and administered by the Government. I have great faith in the American system of free enterprise and initiative. We have done wonders in the medical profession as it stands today, and I feel that any improvements necessary can be accomplished through our system of private practice, with public education and an expansion of our hospitalization and training facilities.
- 3. I am of the opinion that Federal Aid, if any, for health, rehabilitation and medical service should be extended through and administered by facilities of the States. We have too much bureaucracy, government control and inefficiency in Washington today.

I feel that such aid, however given, can be more ably and efficiently administered by the States.

I am glad of this opportunity, as always, to state my convictions. I have great respect and admiration for the medical profession of this State and of the Nation, and I will always be happy to accommodate you in any way.

With best wishes and kindest personal regards, I remain

Sincerely yours,

Wm. Jennings Bryan Dorn

June 15th, 1948

Dr. Julian P. Price Secretary-Editor South Carolina Medical Journal Florence, S. C.

Dear Dr. Price:

Inclosed I hand you a statement in response to the questions stated in your letter of the 10th. I trust that my own comments can be printed in full and that they are not too extensive. Your questions involve very important policies. I am glad to answer them. But I cannot make my meaning clear in less compass.

> Sincerely, Alan Johnstone

Statement of Alan Johnstone:

The Journal graciously opens its columns to me for comment on three questions which seek the definition of private and public enterprise in the field of medicine. The trend of legislation, State and National, in the past two decades has posed the questions. The precise questions are propounded to me as a candidate for the United States Senate and are as follows:

- "1. Are you in favor of compulsory Health Insurance, financed with public funds, as proposed under the terms of the Wagner-Murray-Dingell Bill?
- 2. Do you believe that medical service can best be rendered through a system of private practice such as now exists in the United States, or through a system financed and administered by Government?
- 3. Do you think that Federal aid for health, rehabilitation and medical service should be extended through facilities of the states, or directly through a Department of the central government?"

The outstanding cause of the pre-eminence of South Carolina and America is an idea. That idea is the independence of the individual man. Each man here has been and ought to be free to control his own enterprise and to realize his own possibilities. The State and the Government are his servants and not his masters.

The function of the government is to keep the door of opportunity open; not to occupy the house. Although the constitutions define the powers of our dual government the construction of them by the legislatures and the courts is too often hazy. Public enterprise is confined or ought to be limited to services required by all the people alike in precisely the same fashion; to the control of monoply; and to the care of the wards of the State. So we have schools, highways, public health, navigation, water power, the care of the mentally sick, prisons and the care of the helpless.

Confusion in the field of medicine arises because too often sick people are poor people, or poor people become sick and appeal to our compassion. But to violate sound rules of government in an effort to relieve poverty is not likely to succeed. When the Great Teacher and Healer observed "the poor ye have always with you" He was exhorting His followers to do first things first, and not to mistake the symptom for the disease. While poverty is tragic it results from a blocking of the way of opportunity. More often than otherwise it is not the failure of the individual but of the rest of us, or of the government, to keep the rules of the game of life fair. A poor man needs to be set free and he will find his own way to health and wealth.

Public Health is the means by which we combat the great infections which plague mankind in general. Illness attacks men in particular and requires individual treatment. The Sanatarian practices preventive medicine and is usually a public servant. His strong ally is the physician who in his own practice plays his part and is frequently the means by which preventive measures are taken. Treatment is best administered by a physician of the patient's own choice. The risk is his and he will submit himself willingly only to one in whose skill and integrity he believes. This relation of patient and physician ought not to be invaded by the State, even in the name of better health. For the invasion is not likely to achieve more health and it is certain to mean less freedom, which is more precious even than health.

It follows that I am opposed to the Wagner-Murray-Dingell Bill and similar proposals.

I do believe that medical service can best be rendered through private practice.

I think that Federal aid for health, rc-habilitation and medical service (in connection with the foregoing) should be extended through the facilities of the States rather than through a Department of the central government. There are, of course, eertain wards of the Federal Government with whom it must deal directly and to which these observations obviously do not apply.

We should try to achieve more freedom and less compulsion; more private enterprise and less government at federal, state and local levels. Such public enterprise as we do have should contribute directly to private enterprise by freeing our energies to attend to our own business.

June 17, 1948

Dr. Julian P. Price, Secretary South Carolina Medical Association Florence, South Carolina

Dear Doctor:

I wired you yesterday that I had not answered your letter due to the fact that I had been in South Carolina. You asked me three questions which I am glad to answer:

1. Do I favor the Wagner-Murray-Dingle Bill.

I wrote many of my friends when the bill was first proposed here that I was opposed to this bill, and I wish to say to you that not only will I oppose the bill if it comes to the floor of the Senate, but I will use my every effort to have it defeated.

2. You asked me if I believed that medical funds should be used by the Federal Government without State supervision.

As a member of the Appropriations Committee for many years and on all legislation that has been before the Senate I have always insisted that funds for health and education be turned over to the State for supervision and disbursement. I shall continue to insist that any medical or health funds appropriated by the Federal Government should be under the supervision of the State Health Department.

3. You asked me if I believed in the private practice of medicine.

As you know, both my father and my mother's father were doctors. So naturally the medical profession is very close to me. I well realize the great good that has been accomplished by the private practitioners and also am aware of the great benefits the American people have received from the medical profession. I am very grateful and appreciative of all that has been done not only in the practice of medicine by the doctors but also the remarkable advance they have made in science, in new drugs and in hospitalization. I have always been and will always be opposed to any socialization of the medical profession.

With kind personal regards, I am
Sincercly yours,
Burnet R. Maybank

June 19, 1948

Dr. Julian P. Price Secretary-Editor South Carolina Medical Association Florence, S. C. Dear Dr. Price:

I am pleased to enclose my reply to the questions

submitted by you for publication in "THE IOURNAL".

May I take this opportunity to thank you for this opportunity of expressing my views with regard to this matter. I can assure you of my continued interest in the advancement of medicine and its resultant effect on the welfare of the people of our country.

Sincerely yours, Neville W. Bennett

To the Editor of the Journal of the South Carolina Medical Association:

In response to the questions suggested by you, let me emphasize first, that I am vitally interested in the health of the individual, and that to my mind the physical and mental well-being of the people is of paramount importance. It outweighs any considerations based on the interests, financial or otherwise, of any particular group.

All my life, I have been closely in touch with people in smaller communities and on the farms, and am fully aware of the problems confronting them in obtaining medical care when needed. I do not see how the need could be met more adequately than through the interested care of the family physician.

Experience, I think, has taught us all that the highest quality of service of any kind is to be obtained from him whose success, financially or otherwise, depends directly upon, and is measured by, the quality of that service. Physicians are not different in this respect from others. Medical service can better be rendered through the system of private practice which now exists in the United States, than through a system financed and administered by Government.

I have answered your second question first, because I think it involves the principle which must be

controlling in the decision on any proposed legislation on the subject.

That portion of the pending Wagner-Murray-Dingell Bill, which would set up a system of compulsory Health Insurance, is directly opposed to the principle which governs the system of private practice, and I, in turn, therefore, am directly opposed to that type of Health Insurance. I am against it also for the very reason that it would be compulsory. I think there should be only so much compulsion by Government as is absolutely necessary. The growing voluntary health insurance plans and individual enterprise, have already demonstrated that no compulsion is yet necessary in this field.

The proposal in the Wagner-Murray-Dingell Bill is objectionable on still another ground. It would be financed by public funds. That means it would be financed by taxation and under present proposals, by payroll deduction. I am strongly opposed to deductions from the payrolls of employees of this country of amounts to pay for that maintenance of, and administration of such a system by, the huge government bureaucracy which would be necessarily established. It is impossible to estimate the additional burden that would ultimately result—not for medical care, but for the payment of government officials and employees, and for other administrative expense.

While recognizing the practical necessity for centralized authority in some phases of government, I have always been a firm believer in the principle of States' Rights. Public Health, private medical and hospital service, and rehabilitation are problems which should be dealt with on the very closest possible level to the individual. Federal aid in these fields should be through grants to the states, for distribution and administration through local agencies which are close to the people.

WOMAN'S AUXILIARY SOUTH CAROLINA MEDICAL ASSOCIATION

President: Mrs. P. M. Temples

Publicity Secretary: Mrs. William H. Folk

Knowing we have such splendid cooperation of all Auxiliary members I am looking forward to a very interesting and pleasant year.

With such a fine group of officers and committee chairmen I feel we shall have a very constructive

year.

President-elect__Mrs. J. L. Sanders, Greenville, S. C. First Vice-Pres._Mrs. A. F. Burnside, Columbia, S. C. Second Vice-Pres._Mrs. W. H. Powe, Greenville, S. C. Third Vice-Pres._Mrs. W. R. Mead, Florence. S. C. Fourth Vice-Pres._Mrs. R. B. Bultman, Sumter, S. C. Recording Secretary_____Mrs. R. L. Sanders, Columbia, S. C.

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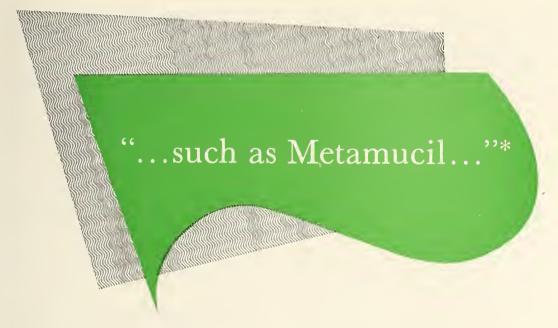
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For the treatment of the spastic colon the author suggests diet, elimination of the nervous element and "bulk producers." As examples of these he lists "agar-agar, in finely powdered form, in flakes, or in cereal-like form; derivatives of psyllium seed, such as Metamucil...."*



"SMOOTHAGE"

IN CONSTIPATION



—"encourages elimination by the formation of a soft, plastic, water-retaining gelatinous residue in the lower bowel."†

Metamucil is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent.

SEARLE RESEARCH IN THE SERVICE OF MEDICINE

Metamucil is the registered trademark of G. D. Scarle & Co., Chicago 80, Illinois.

*Glafke, W. H.: Spastic Colon, M. Clin. North America 26:805 (May) 1942,

†Council on Pharmacy and Chemistry: New and Nonofficial Remedies, 1947, Philadelphia,
J. P. Lippincott Company, 1947, p. 320.

Legislative___Mrs. H. L. Timmons, Columbia, S. C. Bulletin___Mrs. J. H. Gressette, Orangeburg, S. C. Post War Planning_____Mrs. J. A. Siegling. Charleston, S. C.

Nurse Recruitment_____Mrs. R. D. Hill,

Spartanburg, S. C.
These officers and chairmen will be glad to assist all in every way possible; so do not hesitate to call on them at any time.

Mrs. P. M. Temples
President,
Woman's Auxiliary to the South
Carolina Medical Association

WOMAN'S AUXILIARY TO THE COLUMBIA MEDICAL SOCIETY

Mrs. Kirby D. Shealy was officially installed as president of the Woman's Auxiliary to the Columbia Medical Society at the meeting of the auxiliary held Tuesday morning at the beautiful home of Dr. and Mrs. A. F. Burnside in Arcadia. A rising vote of thanks and appreciation was extended Mrs. Manly E. Hutchinson, the retiring president. During the business session annual reports of the work done by the various committee chairmen were given, and reports on the State Medical Auxiliary Convention recently held in Charleston, were given by Mrs. Harry Wilson, Mrs. R. Wilson Ball and Mrs. William Weston, Jr.

Plans were formed by the auxiliary to assist the local Red Cross and the Columbia Medical Society in the establishment of a Blood Bank in Columbia. Mrs. L. E. Madden was appointed chairman of the

committee.

In an interesting talk to the auxiliary, William Mc-Garity and Mrs. William Boyd presented the needs of a maternity ward in the hospital in Berck-sur-Mer, the French town adopted by Columbia. Members of the auxiliary voted to supply and pack these necessities now needed by mothers and infants in Berck-sur-Mer.

The general program of the auxiliary will continue next fall under the supervision of the following new committees: Corresponding Secretary, Mrs. J. E. Freed; Courtesy, Mrs. E. W. Masters; Decorating, Mrs. D. S. Asbill; Entertaining, Mrs. R. L. Sanders; Historian, Mrs. D. D. Caughman; Hygeia, Mrs. L. C. Davis; Iane Todd Crawford Memorial, Mrs. A. T. Moore; Legislative, Mrs. H. L. Timmons; Membership, Mrs. T. D. Dotterer; Nominating, Mrs. R. B. Durham; Nurse Recruitment, Mrs. Carl Lippert; Parliamentarian, Mrs. D. S. Adcock; Public Relations, Mrs. A. F. Burnside; Publicity, Mrs. R. Wilson Ball; Student Loan Fund, Mrs. Hugh Wyman; Telephone, Mrs. Weston Cook, and Program, Mrs. T. A. Pitts.

Following the business session refreshments were served on the lawn beside a lovely lake, where over 60 members of the auxiliary had gathered for the meeting. Mrs. Grady Waddell, chairman of the Refreshment Committee, was assisted by Mrs. T. D. Hopkins, Mrs. John Holler, Mrs. A. I. Josey, Mrs. L. E. Madden, Mrs. R. H. Matthews, Mrs. E. W. Masters, Mrs. S. B. McLendon, Mrs. L. V. Jowers, Mrs. R. G. Latimer, Mrs. G. R. Laub, Mrs. C. M. Lide, Mrs. C. K. Linder, Mrs. M. L. Mathias, Mrs. O. B. Mayer, Mrs. R. B. McNulty, Mrs. G. T. McCutchen, Mrs. Ben Miller and Mrs. Harold Miller. (The above has been submitted by Mrs. R. Wilson Ball, 1622 Valley Road, Columbia, S. C., Publicity chairman for the above auxiliary.)

REPORT OF YEAR 1947-48

It is with a feeling of pride and satisfaction that the Woman's Auxiliary to the South Carolina Medical Association brings to a close the year 1947-48. It has been a year of achievement and of the realization of objectives, a year in which harmony, cooperation, and the desire for service has been evidenced throughout.

In line with National, MEMBERSHIP AND PUB-LIC RELATIONS have been stressed though all other auxiliary objectives have been closely followed.

Growth of the state auxiliary has been extended by the organization of two new district units, composed of five counties each. There are now 12 local units with 28, of the 46 counties in the state, now organized. The membership of 545 is an increase during the year of 140 members.

South Carolina has been alert to the importance of the recruitment of student nurses. Every local unit has supported the campaign. Several intensive drives have been conducted throughout the state, with most gratifying results. There have been two nurse scholarships given.

The Student Loan Fund continues to be an active project, in the hope that it will grow into an adequate amount of money for use in the probable lean years to come.

Historical research has been earried on in each local auxiliary. Fifty-six (56) biographies of deceased South Carolina physicians were collected during the year, making a total of 401 now on file.

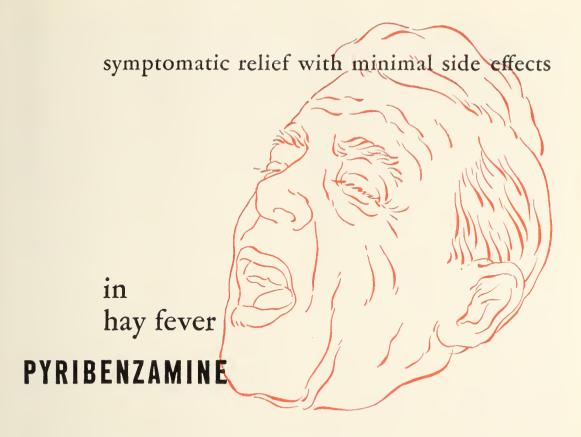
At the request of the Medical Association pictures and biographies of all past presidents of the Association were secured and sent to the historical chairman for a special exhibit at the Association's Centennial Meeting in Charleston, May 12-14. A total of 66 pictures, which were lacking in the files, were secured this year.

Through the splendid cooperation of the Director of Public Relations of the Medical Association an auxiliary publication has been made possible. THE AUXILIARY BULLETIN of the SOUTH CAROLINA MEDICAL ASSOCIATION, published quarterly by the Department of Public Relations, serves as the official organ of the state auxiliary, and has been well received as a medium through which to reach its members. It is mailed to every member of the state organization.

Perhaps the most outstanding accomplishment of the year has been the stimulation of greater interest of the Medical Association in the Woman's Auxiliary, and the awakening of its members to the potentialities of this organization. For the first time a committee from the Auxiliary was invited to meet with the councillors of the Association. This meeting provided an opportunity for a closer relationship and a better understanding between the two organizations, and as a result of this meeting Council voted to appropriate to the Woman's Auxiliary, each year, the sum of fifty cents (50c) per member of the Association to help carry on the auxiliary activities. Council also voted that if, for some special reason, the Auxiliary needed more financial help than the amount quoted above they would be glad to receive and pass upon any special request.

Through the loyal cooperation of the South Carolina Medical Association, the Advisory Board, officers and active members of the Auxiliary the foregoing accomplishments have been made possible. South Carolina looks forward with confidence to years of greater service and progress.

Respectively submitted, Mrs. David F. Adcock, President 1947-48



During the last two pollen seasons, the effectiveness of Pyribenzamine hydrochloride in hay fever has been demonstrated repeatedly ... 84% of 288 cases⁽¹⁾ -78% of 588 cases⁽²⁾ -82% of 254 cases.⁽³⁾

Side effects are few and for the most part mild: — "No serious side effects have been noticed in any patients." "In our opinion, reactions to Pyribenzamine are minimal and seldom necessitate stoppage of the drug." (4) The usual adult dose is 50 mg. four times daily.

- 1. ARBESMAN, C. E.: N. Y. State Jl. of Med., 47: 1775, 1947.
- 2. LOVELESS, M. H.: Am. Jl. of Med., 3: 296, 1947.
- 3. Bernstein, Rose and Feinberg: Ill. Med. Jl., 92: 2, 1947.
- 4. Osborne, Jordon and Rauscii: Arch. of Derm. & Syph., 55: 318, 1947.

Pyribenzamine Scored Tablets, 50 mg., bottles of 50, 500 and 1000. Pyribenzamine Elixir of 5 mg. per cc., bottles of 1 pint and 1 gallon.

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(Con't. from p. 235)

several meetings during the past year. From our continued study, we have become increasingly impressed with the gravity of the cancer problem in our state. We continue to lose about 1,400 of our citizens each year from cancer. This is a death rate of one about every 6 hours. From the best information we have, it is our opinion that a large number of these lives, probably one-fourth and possibly one-half, could be saved if proper treatment were given early in the disease. The answer then to the problem seems to be a continuation of our efforts to disseminate information about cancer among the citizens of our state, and to help the members of our profession to become not only cancer conscious, but increasingly skillful in the treatment of this disease.

We regret to report that factual data from the nine eancer clinies is not available. This is due, in part at least, to the fact that during the time these cilines have operated, competent clerical help was not available to keep satisfactory records. All the clinics have been notified that they will be expected to make detailed annual reports to the Cancer Division of the State Board of Health from now on. We do have, however, this general information-that the clinics are being used more each year. In 1946-1947 the average number of new cases of cancer attending the clinics each month was 60. In 1947-1948 the average number of new patients was 90. It is interesting to note that by far the most frequent lesion treated in the clinics since 1941 is cancer of uterus. Through 1947 over 1,600 patients with cancer of uterus have been treated, and during the same period 671 breast cancers were treated. The fact that, during this period, 104 cases of eancer of stomach and 93 cases of cancer of colon and rectum were treated, would indicate that relatively fewer cancers of stomach and colon are being found and sent to elinics, because this ratio does not reflect the ineidence ratio of cancer in these organs. Until our Cancer Division of the State Board of Health is able to compile factual data from all the clinics, reflecting the degree of success we are having in treating these unfortunate patients, we will continue to work in the dark. When we are able to tell our patients that a certain definite number of cancers of uterus, breast, colon, etc., have received five or ten year cures in the cancer clinics of our state, then our patients, and to some extent, the members of our profession will be more enthusiastic about sending patients to clinics earlier. There has been marked increase in the cost of hospital care of cancer patients. The average cost per patient in 1946-47 was \$33.00, while the average cost per patient for 1947-48 is \$62.00.

According to a study of the American Cancer Society, a cancer elinie may efficiently serve a population of about 100,000. According to this ratio, several more clinics should be established by the hospitals of our state when the minimum requirements of the American College of Surgeons can be met.

Cancer Detection Centers have been established in Anderson, Columbia and Orangeburg. It is too early yet to appraise these Cancer Detection Centers in our State, but according to the experience of the American Cancer Society, in many other states this has been found a very effective way of encouraging people to have periodic health examinations and, in a small percentage of cases, early cancer is detected. In Anderson, the Cancer Detection Center earries the definite label of County Medical Society. The members of the staff are selected by the County Medical Society to serve for a year and the people of the community understand that this service is offered by the organized medical profession in the interest of the health of our eitizens.

The committee recommends that other detection centers be started, always under the auspices of the County Medical Society.

The growth of the South Carolina Division of the American Cancer Society has been remarkable. It is a very outstanding illustration of the value of the voluntary health organization. Besides providing for field workers in connection with five of the cancer clinics, the Society carries out a very valuable form of service to the cancer patient in the home. Drugs, dressings and some nursing care to cancer patients in the terminal stage are provided.

One of the valuable pieces of work of the Cancer Society is in the educational department under the able direction of Dr. Velma Matthews of Coker College. Much interest has been aroused in the colleges and high schools through the work that is being carried out in this department.

The need which has not been met in our State is the appointment of a speaker's panel, consisting of doctors located in different parts of the State who may be called on to make talks on cancer at public mee'irgs. This recommendation was made in our report of last year and, while the report was adopted, so far as I know, no group of doctors were appointed.

The American Cancer Society is now setting up a nation-wide panel of some three hundred doctors who may be secured for medical meetings in the several states. The American Cancer Society proposes to pay these doctors a small honorarium and the South Carolina Cancer Society has recently decided to pay the expenses of speakers from this panel who are invited into our State to address medical groups.

Your committee, in closing, would recommend that at each annual meeting of our State Society, some outstanding man be secured to address us on some phase of cancer.

We recommend that district societies and some of the larger county societies avail themselves of the opportunity to secure speakers from this national panel.

We recommend that a panel of doctors in our own State be appointed by the President to serve on the speaker's bureau in the interest of cancer education in our state.

We further recommend that all the members of State Medical Society lend their support in promoting the Caneer Society in our State.

> Respectfully submitted. I. R. Young, M. D. Chairman

The Chair: You have heard Dr. J. R. Young's report. I don't think it carries a resolution. He merely recommends that the President appoint a committee, is there any comment on that? Do I hear a motion?

(It is moved, seconded and carried that the president appoint a committee)

The Chair: Report of Committee on Scientific Work-Dr. John Boone.

(No report handed up-Dr. Boone stated that the seientific program, as planned for the convention, would be his report.)

Dr. Young takes the Chair: We will hear the Report of the Committee of Eighteen-Dr. Olin B. Chamberlain.

REPORT OF THE COMMITTEE OF EIGHTEEN

Council, at the Myrtle Beach meeting in May 1947, appointed a Committee to make a survey of the State Board of Health and to determine what changes, if any, appeared to be advisable. The committee consisted of the President of the Association, who was named Chairman, the Secretary of the Association, Dr. J. P. Price, and the following additional members: Dr. Roderick MacDonald, Dr. A. L. Black, Dr. H. J. Stuckey, Dr. A. C. Bozard, Dr. E. B. Michaux, Dr. J. S. Fouche, Dr. D. L. Smith, Jr., Dr. F. G. Cain, Dr. Ned Camp, Dr. W. W. King, Dr. Joe Cain, Dr. Hugh Smith, Dr. G. C. Brown, Dr. C. H. Blake, Dr. R. L. Crawford, and Mr. M. L. Meadors who was named Secretary. This made a total of eighteen members and the Committee became known as the Committee of Eighteen.

Creation of the Committee was a result of the expression of sentiment by members of the General Assembly during the 1947 session, pursuant to recommendations made by Governor Thurmond in his inaugural address, that the Board be reorganized with greater representation of non-professional groups. It will be recalled that at a Hearing before the Senate Committee on Medical Affairs in April 1947, for the purpose of studying the question, and certain bills which were about to be introduced, the suggestion was made and agreed to that no action be taken by that Committee during the then current session, with the understanding that the Medical Association would make a study in the interim and submit recommendations to the Legislature in 1948.

The Committee of Eighteen held its first meeting at the Columbia Hotel in Columbia on June 1, 1947, at which time the matter was discussed generally, and the members apprised of the nature and seope of the responsibility and authority delegated to them by Council. Preceding this meeting, the Chairman had made certain preliminary inquiries in the effort to determine what appeared to be the most feasible means of conducting the proposed survey. He pointed out that, since the Committee was composed of physicians in active practice, without the time or, in most cases, the inclination to conduct this sort of intensive study, it seemed advisable to employ some outside individual or agency qualified for the work, to make the survey. It was recognized that the Committee was charged with the duty of conducting an impartial study with the view to recommending any constructive changes, which might appear to be in the interest of the people of the State. The Chairman suggested that possibly the services of the American Public Health Association, the Roekefeller Foundation, or some similar organization might be obtained for the purpose.

The Committee agreed with the general idea and at this meeting, after full discussion, appointed a sub-committee, composed of the Chairman, Dr. F. G. Cain and Mr. Meadors, who were authorized "to procure as soon as possible the services of some impartial outside agency to make a thorough study of the administration and policy of the State Board of Health, obtain all available information as to its activities and

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compare the same with the policy, administration and activities of Boards of Health in neighboring states, and that such agency make a report of its findings and recommendations to this Committee at a subsequent meeting."

Accordingly, the Chairman, within the next few weeks, contacted several of the agencies and, at the meeting of the American Medical Association at Atlantic City in June, conferred at length with Dr. Atwater, Executive Secretary of the American Public Health Association, with a view to obtaining their services. Shortly afterward, Dr. Atwater notified the sub-committee of the inability of his organization to conduct the survey, due to previously seheduled commitments, and suggested that Dr. Harry S. Mustard, then President of the American Public Health Association, might be available for the purpose. Following this suggestion, after some correspondence followed by conversations with him while he was in South Carolina during the summer months, Dr. Mustard was employed to make the necessary survey and submit his recommendations to the Committee. The survey was conducted by Dr. Mustard in August 1947, and on September 13th he filed a comprehensive report with specific recommendations, a copy of which is submitted herewith.

The Committee of Eighteen then held another meeting in Columbia, ten days prior to which each member was furnished a copy of the Mustard Report, with the request that he consider it carefully and be prepared to discuss the findings and recommendations. The meeting, on October 19th at the Columbia Hotel, was well attended and the Committee, while agreeing in general with the purport of Dr. Mustard's findings and suggestions, adopted some changes in the recommendations. A copy of the recommendations as adopted by the Committee for submission to the House of Delegates, is likewise submitted herewith.

A special meeting of the House of Delegates was called to consider the report of the Committee on Sunday, November 23rd, at the Columbia Hotel. The Chairman made the report for the Committee and submitted its recommendations. When the subject was opened for discussion the Delegates expressed themselves freely and a number stated their reactions frankly. After a full discussion, pro and eon, a motion to adopt the Committee's recommendations as submitted was passed by a wide margin and the Chairman of the Committee was directed, with the assistance of Mr. Meadors and any others whom he might find it advisable to call upon, to have a proposed bill drafted embodying the recommendations and to take the necessary steps to have it enacted into law.

Accordingly, a proposed bill containing the identical provisions of the recommendations adopted by the House of Delegates, was prepared by Mr. Meadors and presented by the Chairman of the Committee of Eighteen to Senator Baskin, Chairman of the Senate Committee on Medical Affairs, a short

time after the legislative session convened. These gentlemen held the matter without any action for several weeks and on February 14th we were advised that the Committee was considering seriously other bills providing for a minority of doctors on a Board of nine or cleven members.

Accordingly, a joint meeting of Council and the Committee of Eighteen was called and held in the Jefferson Hotel on Tuesday, February 17th, to determine what steps should be taken under the circumstances. The joint meeting had before it copy of a proposed bill which had already been drafted for introduction as a proposed Medical Affairs Committee Bill, providing for a Board of eleven members: five physicians, one dentist, one registered nurse, one graduate pharmacist, and three other citizens to be appointed by the Governor. It provided further for the establishment of a Department of Health to be under the general supervision of the proposed Board of Health, and under the executive direction of the State Health Officer. In all other respects the Bill was virtually the same as that proposed by the House of Delegates, After considerable discussion, it was the sense of the joint meeting that we must insist upon an organization as nearly as possible in line with the recommendations adopted by the House of Delegates. The idea of the provision in the proposed bill for a Department of Health was specifically disapproved and the Chairman and the Director of Public Relations and Counsel were directed to proceed accordingly.

On the same day the Medical Affairs Committee of the Senate held a Public Hearing to consider the proposed bills for reorganization of the State Board of Health, of which there were at least three. The Chairman of the Committee of Eighteen stated the position of the State Medical Association, pointing out that a careful survey had been made, that the recommendations embodied the best judgment and studied opinion of the Medical Association, and the Senators were requested to introduce the Bill as submitted. The Senate Committee took no action that day but considered the matter at several subsequent meetings, at all of which we were represented by Mr. Meadors. Finally, on March 11th, the Committee introduced a Bill providing for a newly constituted Board with a membership of eleven, consisting of six doctors to be named specifically by the State Medical Association, one pharmacist, one dentist, one nurse, one hospital administrator, each to be named by their respective State Associations, and one other to be named by the Governor. The Bill was otherwise as recommended by the House of Delegates, except that it contained the provision for the establishment of a Department of Health. It received a second reading on March 18th, with a notice of general amendments on third reading, and an amendment to eliminate the objectionable paragraph providing for the Department of Health was on the desk for consideration when the Bill should be reached for debate.

By that time, however, the Calendar of the Senate had become congested with controversial matters ahead of the Board of Health Bill, and the latter never received a third reading and was not debated. On Friday, April 9th, it was referred, on motion of Senator Abrams of Newberry, to the newly created Reorganization Committee for study and recommendation to the General Assembly in 1949. This Commission, appointed under the terms of the Reorganization Aet adopted this year, will be made up of thirteen members including: Senator Harvey of Beaufort, Chairman of the Senate Judiciary Committee: Senator Brown of Barnwell, Chairman of the Senate Finance Committee; Senators McLeod of Richland, Warren of Hampton and Pruitt of Anderson; Representatives Plowden of Clarendon, Chairman of the Ways and Means Committee; Anderson of Greenwood, Chairman of the House Judiciary Committee, Gaines of Spartanburg, Legge of Charleston and Spivey of Horry. Three other members to be appointed by the Governor have not been named at the time this Report is prepared.

The personnel of the Commission so far is such as to indicate that the Board of Health measure and other matters presented to them will receive careful and wise consideration. Since its membership is not yet complete, of course the Commission has not organized nor announced any plan of procedure. What action it may recommend with respect to the State Board of Health presumably will be presented to the next Legislature when it convenes in 1949.

Until that time at least, therefore, there will be no change in the organization of the State Board of Health or its Executive Committee.

The Chairman wishes to thank all the members of the Committee of Eighteen for their active interest and their full cooperation. Every meeting of the Committee was well attended, the members kept themselves well informed on the progress of the survey, and subsequently, offered suggestions and entered into the discussions fully, and responded when called upon for any assistance in connection with legislative developments, and otherwise. The Chairman feels that the Committee undertook its work seriously and attempted fairly to render assistance to the State as well as to the Association.

Respectfully submitted, Olin B. Chamberlain Chairman

Dr. Young (Presiding): Gentlemen, you have heard the reading of this committee's report, what is your pleasure?

Dr. Haynes: I move the report be received as information. (This motion was seconded and passed unanimously.)

Dr. Chamberlain (Resumes the Chair): Next is the Report of Committee on Legislation and Public Policy—Dr. George D. Johnson, Chairman.

REPORT FOR THE COMMITTEE ON LEGISLATION AND PUBLIC POLICY

The Bill to reorganize the State Board of Health did not progress further than the second reading in the Senate. That means that at least for one more year the State Board of Health will be conducted as it has been in the past. The Bill was referred to the Reorganization Commission, for study. That body was appointed under the terms of the Reorganization Act passed early in the session. It is composed of three Senators, three members of the House, the Chairmen of the Senate Finance Committee, the Senate Judiciary Committee, the House Ways and Means Committee, the House Judiciary Committee, and three citizens to be appointed by the Governor. The last have not vet been appointed. The personnel of the Commission is such that it is felt sure that the Bills referred to it will receive wise consideration.

The Bill to provide for the establishment and incorporation of non-profit, tax-free, medical prepayment plans was enacted into law on March 19, 1948, and became effective on April 5, 1948, when it was signed by the Governor. The State Medical Association, or for that matter, any County Medical Society, is at liberty to proceed with the establishment of such a plan.

The Bill to provide scholarships at the Medical College, as an inducement to young physicians to locate in rural communities, has been passed by both Houses and it is assumed that the Governor will sign it. As soon as his signature is placed on it, the scholarships will be available, beginning with the college session which opens in September 1948.

The Resolution to provide for an investigation of the Board of Naturopathic Examiners, after three separate hearings before the Senate Committee on Medical Affairs, was considerably modified by that body and so adopted by the Senate and the House. As it stands now, the Resolution provides for an investigation by the Board of Naturopathic Examiners themselves, rather than by a legislative committee. The Board is directed to make use of the information developed by the investigation made by the Chief Law Enforcement Officer last year, and to take the necessary steps to revoke licenses improperly granted or held by unqualified licensees. It is further directed to make a report to the next General Assembly on the opening day of the 1949 session as to its actions on the Resolution. The Naturopaths are thus given an opportunity to elean their own house and the investigation could have good results if pursued in good faith. The Resolution is better than nothing and may be a step toward something more constructive next

During the year whenever any important legislation came up in the Capitol of our State, certain doetors in different counties were notified and asked to be present. The attendance at these sessions was a very poor reflection on our interest, and if we continue to neglect this phase of our medical affairs we cannot expect much cooperation from the State Lawmakers. On one occasion when there was an open hearing, every Naturopath in the State was there, and their lawyers were present to represent them, whereas there were only one or two doctors present. When Julian Price or Mr. Meadors sends out any type of call to come to Columbia, they do not do it simply for show, it is for a definite purpose, and if a doctor can possibly get away, he should make every effort to attend.

As regards public relations, the doctors, from an individual standpoint, are highly thought of in a community. However, the doctors as a whole, especially in large cities all over the country, are getting a great deal of criticism because they refuse to answer night calls. In some eities in our State this is also true and our State Medical Association is getting considerable adverse criticism because of this. The American Medical Association has sent out an appeal to doctors not to forget that our first duty is to the patient, regardless of the circumstances, even though you and I know that a great many of them are drug addicts or chronic alcoholics, and people who refuse to pay their bills. Occasionally a well meaning one will be desperately sick at night and not be able to get a doctor.

Another point that has come up here in the last year, is the formation of the South Carolina Citizens Committee on Health and Youth. This committee is composed of a great many representatives from different organizations all over the State, and includes the Medical Association. In each eounty, it is eventually hoped, the committee will be set up and every doctor who is on this committee in his respective county has been notified and a list of questions which the South Carolina Citizens Committee hopes to answer as regards health, has been placed in his hands. This Committee may never amount to anything, but the doctors want to be ready to answer any questions that may come up. Doctors, as you know, have been criticised for not taking part in community projects, and this is one time when we can lead the way. It seems only fair that we should because, after all, we should control the health in our communities and if we are well posted and take an interest, the Medical Profession will be better thought of than if we do not.

The medical profession has also been accused of not cleaning its own house before trying to correct someone else. This is especially true as regards the kick-back in the case of Opthalmologists and also as regards practicing physicians who not only use narcotics and alcohol to excess, but preseribe narcotics and barbiturates freely to too many patients. It is sincerely hoped that the Opthalmologists in the State will get together and put an end to this because I do not think other doctors will take it upon themselves to take them to task. In other places, I under-

stand Opthalmologists have taken the lead and if everyone gets together, there is no reason why this highly criticised practice should not stop. As regards doctors who use drugs and alcohol to excess, that is something that we have always been in a quandry about, and if anyone has a good suggestion, I think the House of Delegates would be glad to hear it. Never-the-less, doctors are criticised for this. There are some in the profession who think that their licenses should be taken away, at the instigation of the County Medical Society, and there are others who think that they should be left alone. As long as patients go to them that is the patient's responsibility.

An appeal is made to every physician to respond to the help of Mr. Meadors and Dr. Priee whenever either of them sends out a call.

The relation of the Medical Profession to the public can be improved in certain instances and we, as doctors, should strive to do so.

Respectfully submitted, George D. Johnson, M. D. Chairman

The Chair: Report of Committee on Medical Care for Veterans—Dr. Charles N. Wyatt, Chairman.

Dr. Wyatt: Mr. President, gentlemen of the House of Delegates, the only report your committee has on veterans' carc is the resolution that we want to present to the House of Delegates today in that "in renewing the eontract with Veterans Administration that we remove the intermediary, which is "Hospital Service Plan of South Carolina" and deal with Veterans Administration, direct." Also, "that we have a new fee schedule which your committee has investigated and compared with the old one and there is very little difference in the fee."

This is the recommendation that we make:

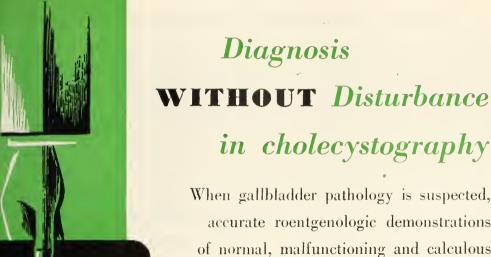
"That we sign the contract with the Veterans Administration for the State Medical Association, as the agent, and do away with the intermediary, which has been the Hospital Service Plan of South Carolina."

The Chair: Thank you, Dr. Wyatt, will you place that in the form of a recommendation before the Resolutions Committee?

Next in order is the Report of Committee on Public Health and Instruction—Dr. R. M. Pollitzer, Chairman.

REPORT OF THE COMMITTEE ON PUBLIC HEALTH AND INSTRUCTION

The Committee on Public Health and Instruction has met several times and discussed what kind of work should be undertaken. We thought at the outset that the assembling of data as to the quantity and quality of medical service rendered to the people of South Carolina, should be first determined. This proved, however, to be too ambitious an undertaking. It was then decided that it would be well to acquaint the public with what modern medicine has to offer in the way of prevention and treatment of disease.



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As all of us well know, there have been marked advances in immunization, the care of the infant, the treatment of infectious diseases, and the prolongation of life, along with a decrease in the ills of the aged.

Today, however, the city and county health agencies, along with the State and National Associations, and such organizations as the Cancer, Tuberculosis and Poliomyelitis Foundations, are all constantly on the air and in the press, awakening the public to the dangers that lie in wait. This Committee, therefore, is of the opinion that such work on our part is not really needed and could not compete with what is already being done.

On the other hand, one hears and reads of much discontent with medicine as it is practiced today. While the dissatisfaction in a large measure is unfounded, yet there are certain grievances which are justifiable. To be specific, and as has been so well pointed out by Dr. John T. Hundley of Lynchburg, Va., while medical science has progressed amazingly in our time, yet quite often the individual patient feels that he is just another case to his doctor and he resents the use of machines and many tests and misses the personal interest in himself.

Furthermore, there is no question but that, because doctors are so often unable to keep appointments, there develops considerable carelessness in punctuality. While time may not be of value to all our patients, yet to some it is of great importance. These people are embittered by having to waste time waiting and stay away from the doctor's office as much as they possibly can.

Everyone knows that the cost of equipping and maintaining an office has tremendously increased within the past twenty years. Patients have become accustomed to various diagnostic methods, such as x-ray, basal metabolic rate, blood studies, etc., which are in everyday use, and they expect them. The cost of medical care, rather than the quality is considered and discussed by the laity so much that doctors are often unjustly criticized. However, while in general doctors' charges are not excessive, here and there we hear of bills that are very unreasonable and out of line for the service rendered. This causes much resentment, not only against this particular physician, but against the whole profession. Unquestionably, the vast majority of doctors are primarily interested in the art and science of medicine and rendering the best possible service to their patients, yet a few have as their first consideration, pecuniary gain.

If the practice of medicine in its many branches is not to be controlled by the Federal Government, then the quality, adequacy and availability of service rendered the people, with fees within the means of its recipients, must all be satisfactory. That is, the rights of both the practitioner and the patient must be satisfactory to each and be safeguarded.

It seems to your Committee that, instead of trying to educate our patients along lines of public health, it is far more necessary to try to maintain cordial relations with the public and let them know something of our sociological and economic problems. We need more than anything else to try and salvage our badly deteriorated public relations.

Therefore, we recommend that the Committee on Public Health and Instruction be discontinued, and in its place a new committee established. This could be called the Committee on Public Relations, and should have as its executive secretary, Mr. M. L. Meadors of the State Association.

Respectfully submitted,

R. M. Pollitzer, M. D. Chairman J. I. Converse, M. D. W. S. Fewell, M. D. J. D. Parker, M. D. E. B. Poole, M. D.

The Chair: The Resolution Committee will take cognizance of that recommendation. Thank you, Dr. Pollitzer.

Report of Committee on Hospital Service—Dr. Robert Wilson, Jr.

REPORT OF COMMITTEE ON HOSPITAL SERVICE

At the last meeting of the House of Delegates of the State Medical Association the South Carolina Hospital Service Plan was just beginning its operation. There were very few subscribers and many hospitals had not yet become members. There was still considerable uncertainty in the minds of many whether or not the Blue Cross Plan would succeed and financial operations one year ago and for some months afterwards remained in the red.

During the past year membership has jumped from the initial three or four thousand to over forty thousand paid up subscribers at the present time. The past six months have added ten new hospital members and now twenty-eight hospitals out of about forty eligible hospitals in the state are member institutions. Almost all of the hospitals who have remained outside have done so because of inacceptable financial arrangements and as soon as the Hospital Service Plan is able to meet the cost of hospitalization in these institutions, so that they will not have to accept Blue Cross patients at a financial loss, almost all of the remaining hospitals will doubtless join in. Finanical operations have been at a profit since January, 1948 and as soon as the hospital service plan can increase payments to hospitals this will be done.

No definite settlement has been reached with the group of radiologists and anesthesiologists, but negotiations with these groups have not broken down



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and it is hoped that arrangements satisfactory to all parties concerned will be made in the very near future.

The South Carolina Hospital Service Plan is now a going concern and well merits the continued approval of the South Carolina State Association. The more we can educate the general public in prepayment plans for the purchase of unexpected hospitalization, and perhaps later of medical and surgical attention through the Blue Shield Plan, the less will be the likelihood of state control of medicine.

Robert Wilson, Ir.

Dr. Robert Wilson: I have been unofficially informed by a member of this group that there have been no negotiations (referring to his next to last paragraph of his report). I don't know what the score is on that subject.

Dr. Augusta Willis: (Recognized by The Chair)

I was appointed as a committee from the radiologists by this association to meet with the Blue Cross Committee of the Hospital Association. Mr. Buchanon wrote me a letter that they would meet with me. I wrote him any date he set I would be delighted to meet with him, any time. I sent him a verbal message recently to that same effect and his answer was that "sooner or later, he guessed he would have to meet with us."

The Chair: Thank you Dr. Willis. Is there any further comment?

If not, we will now have Report of Committee on Medical Service—Dr. J. D. Guess.

REPORT OF THE COMMITTEE ON MEDICAL SERVICE MAY 11, 1948

Mr. President:

Your committee is able to report that at long last, the General Assembly, recently adjourned, completed the enactment of the bill, prepared by this committee, which makes possible the organization and operation of non-profit medical service organizations, popularly called Blue Shield organizations. A copy of the act is attached hereto and is a part of this report. Medical Service or Bluc Shield Associations provide insurance against the professional costs (doctors' fees) of illness, in a manner similar to that in which Blue Cross organizations offer insurance against hospital costs of illness. Both operate on a non-profit basis, and with limited benefits which are determined by a board of directors, and which are incorporated in the contracts with the insured and which must have the approval of the State Insurance Commissioner.

The State Association is now in position to proceed with the organization of a medical service association for South Carolina, but before even preliminary steps are taken, certain basic questions should be given consideration. Some of these are:

Are the members of this association interested in the organization and wholeheartedly in favor of such an association, will they support and promote it, and

will they be sympathetically understanding and patient during the earlier months or even years of its operation, realizing that this is a new enterprise, of potentially large proportions, but which in order to develop soundly, must necessarily develop slowly, and that during these development years, the sponsoring and participating doctors may very well be forced to accept some personal sacrifices.

A second question is, the extent of coverage to be offered at first: Surgical, medical, obstetrical, in hospital cases only, or in home, hospital, and office. This should be left to the decision of a board of directors, but their decision should be accepted by this association as wise and best.

A third question is the type of settlement of claims, whether on a purely service basis or by cash indemnity, or by a combination of both. This again should be left to the decision of a board of directors.

Finally, there is the question of a fee schedule for the illnesses covered by the contract. There seems to be an increasing tendency to charge about all the traffic will bear. If a fee schedule is written on such a basis, the whole scheme will be doomed to failure. Instead, the committee believes that the fees provided should be lower than average charges, and that credit should be given to the fact that 100 per cent collections would compensate probably for a twenty per cent reduction in current charges, and would yield approximately equivalent income ultimately.

These questions are mentioned, not for discussion or decision at this time, but to direct your thought to some of the problems which must be worked out in organizing a Blue Shield Association. If you are unwilling to delegate their determination to your representative, and if you feel that you cannot participate in and support an organization of this type unless it settles these questions to your individual liking then it were better that you oppose the plan from the beginning.

The committee recommends that the House of Delegates authorize and instruct the Council to further study the advisability of proceeding with the incorporation of a medical service plan for South Carolina, in accordance with the laws and regulations applicable.

In connection with these recommendations and forming a part of this report, is attached hereto certain documents, which are designed to serve as an outline and a basis for discussion and decision by the council when it comes to consider actual plans and procedures in carrying out the proposed mandate.

The chairman wishes to publicly express his appreciation to the other members of the committee for their excellent assistance in this project, and to Mr. M. L. Meadors for his excellent cooperation in preparing the bill and watching its passage through legislative channels.

J. Decherd Guess, M. D. Chairman Report of Committee on Industrial Health—Dr. Harry Wilson, Chairman.

REPORT OF COMMITTEE ON INDUSTRIAL MEDICINE

There are forty-five State Medical Associations that have Committees on Industrial Medicine. Last June, your President appointed the undersigned Chairman of such a committee for the South Carolina Medical Association. This committee is composed of the following physicians: Dr. W. C. Herbert, Jr., Spartanburg; Dr. R. Dennis Hill, Pacolet; Dr. J. G. Murray, Greenville; Dr. G. P. Richards, Charleston; and Dr. Harry F. Wilson, Columbia, Chairman.

According to Dr. Carl Peterson, Secretary, Council on Industrial Health, American Medical Association, the following are the essential functions of State Committees on Industrial Medicine or Health:

- To inform industry and labor of the value of industrial health conservation.
- To develop a clear understanding of the proper scope and functions of industrial medicine and to clarify relationships between private and industrial practice.
- To keep the medical profession informed about all accepted methods for reducing the frequency and severity of industrially induced disability.
- To elevate medical relations under workmen's compensation.
- 5. To scrutinize all legislation affecting the health of industrial workers.
- 6. To improve relationships between medicine and insurance
- To establish working relationships with all agencies in the state interested in industrial health.
- 8. To arrange for the adoption of similar activities through cooperating committees in the medical societies of the industrial counties.

As recently as twenty-five years ago, a physician who accepted a position in industrial medicine was considered to have stepped down from a high professional plane to one distinctly lower. It was assumed that the quality of medicine practiced would be lower and that the physician would become more and more commercially minded. Today we see a different picture because many large commercial and industrial organizations have well-organized medical departments headed by a full-time physician. According to my knowledge, there is not a physician in the state at the present time affiliated with industry on a fulltime basis. However, there are a number of physieians practicing industrial medicine in South Carolina on a part-time basis and this number will probably increase because this state is rapidly becoming industrialized. Industrialists will look in the future to the industrial physicians and general practitioners for guidance in providing a safe working environment.

The field of industrial medicine is now included in the recently revised essentials of approved residences and fellowships prepared and issued by the Council on Medical Education and Hospitals of the American Medical Association. This is one of four new classifications which have been added to the residency list which was approved by the A.M.A. House of Delegates at the 1947 annual session. Plans are being formulated by A.M.A. Headquarters for several medical schools in cooperation with the industrial medical departments of large plants to provide adequate teaching facilities and practical experience to physicians wishing to take advantage of such training.

Your committee makes the following recommendations:

- 1. That the State Medical Association urge its members to report known cases of occupational diseases on the weekly morbidity card. An occupational disease may be defined as one which occurs with characteristic frequency and regularity in occupations where there is a specific hazard as the cause which operates to produce effects in the human body recognized clinically as pathological changes and effects produced by the specific occupational hazard involved.
- 2. That the Association urge the Medical College of the State of South Carolina to broaden the program for undergraduate teaching of industrial medicine and health. It is our belief that such a program should not aim at developing specialists in industrial medicine but make better general practitioners of the graduates by acquainting them in their formative undergraduate days, with the problems of this field of medicine and emphasizing the importance of differential diagnosis as it pertains to industrial medicine in their everyday non-industrial practice.
- 3. That the Association urge district and county medical societies to appoint or designate a representative on industrial medicine to work with the state committee.
- 4. That the Association urge industry to make provision for employing the physically handicapped individuals provided they are not infectious to anyone.
- 5. That the Association urge industry to require a pre-employment or preplacement physical examination, including an x-ray of the chest and blood serology. The purpose of these examinations is not to deprive individuals of employment but to serve as a basis for the proper placement of prospective employees with physical defects in order that they will not be a potential source of danger to themselves and their fellow workers.
- 6. That the Association urge program committees of the Post-graduate Seminar of the Alumni Association, District and County Medical Societies to include in some of their scientific programs a nationally known speaker on the subject of industrial medicine.

 That the Association encourage its members to prepare articles on industrial medicine for publication in the State Journal.

In conclusion, your committee believes that industrial medicine is definitely increasing in importance and greater emphasis should be placed upon this particular field of medicine. Industrial physicians in the future will be confronted with additional medical problems due to radiation and radioactive material. These problems will deal with protection and definitive treatment whenever atomic energy is used extensively by industries.

Respectfully submitted, Harry F. Wilson, M. D. Chairman

The Chair: Thank you for your report, it is a good report. Are there any comments on that report? If not it will be received as information.

The Chair: We have now come to New Business. Under that head there are some resolutions to be offered.

Dr. Price: The following resolution was passed by the House of Delegates last year. It had to lie on the table for one year. It is brought now for vote—it is a change in the Constitution.

"Resolved that the Constitution shall be amended to read

(ARTICLE VI)

The Council shall consist of the Councilors and the President, the Vice-President, the President-Elect, the Secretary, and the delcgate(s) to the American Medical Association."

This is in line with the actions of various other State Medical Associations where the delegate to the A.M.A. is included as a member of council for he is the liaison man between the state and the A.M.A.

The Chair: Gentlemen, as your Secretary says, this amendment to the Constitution was passed last year and is up now for final voting. Change in the Constitution and By-Laws must be carried by a two-thirds vote. I will ask for a standing vote.

Do I hear a second that this amendment be accepted?

(Motion seconded)

Is there any discussion? If not, we are ready for the question. All in favor will please stand. It appears to the Chair that the standers have carried it and that shall become a part of the Constitution.

Dr. Price: Your secretary was asked to frame this resolution by Council and present it this afternoon.

"BE IT RESOLVED, that this House of Delegates vote its disapproval of legislation now being considered by the National Congress calling for the registration and subjection to draft of all physicians up to age of forty-five (45). We believe that this is not only discriminatory but that it would be inimical to the health and medical welfare of the people of South Carolina, and

BE IT FURTHER RESOLVED, that a copy of this resolution be forwarded immediately to each Member of Congress from South Carolina."

The Chair: You have heard the resolution. (It is seconded by Dr. Haynes) Is there any discussion? Hearing no discussion we will proceed with the question. All in favor will signify by saying "aye". (The "ayes" were unanimous.) It is so ordered.

Dr. Deckerd Guess: (Recognized by The Chair)

At the request of the South Carolina Obstetrical Society I asked permission to stand before you and present a resolution which the South Carolina Obstetrical Society thinks is in the interest of maternal welfare in South Carolina. The resolution is as follows:

"Be it directed by the House of Delegates of the South Carolina Medical Association, that the president appoint annually a committee to be designated, "The Committee on Maternal Welfare of the South Carolina Medical Association," which committee will be charged with conducting a continuous study of maternal mortality in our State and with making such recommendations and taking such steps within its power which would seek to bring about a lowering of our mortality rate;

And be it resolved further, that this committee shall consist of the following:

An obstetrician, and a member of the Association, who shall be nominated annually by the South Carolina Obstetrical and Gynecological Society, and who shall serve as chairman of the committee;

The Director of the M.C.H. Division of the State Board of Health, provided he be a member of the Association;

Three other members of the South Carolina State Medical Association to be selected by the President of the Association, and who are general practitioners actively interested in and engaged in the practice of obstetrics."

L. A. Wilson, M. D., Chairman W. A. Hart, M. D. J. Decherd Guess, M. D. Committee, South Carolina Obstetrical and Gynecological Society

The Chair: Gentlemen, there was such a committee formerly and that committee did excellent work. This communication was read before Council and Council felt it was a wise suggestion. Dr. Guess is not a Member of the House of Delegates, so this communication cannot be put forward by him as a resolution. If any Delegate will signify it as his resolution?

(This motion was made and seconded that the resolution as read at the direction of Dr. Guess be voted on; there was no discussion; the resolution was passed by a unanimous vote.)

The Chair: This calls for the formation of a Committee, not now in the By-Laws. There may be an amendment to a By-Law at any annual meeting if it is passed by a two-thirds vote of the delegates pres-

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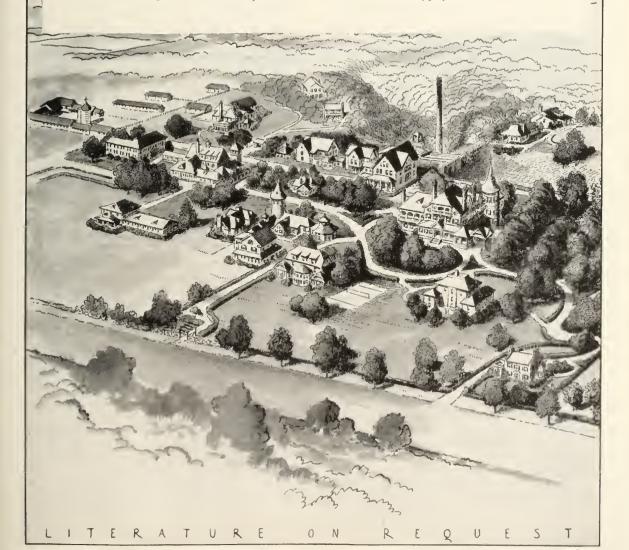
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ent. All in favor of that signify by raising your hands. (All opposed now raise your hands) It is so ordered.

Is there any other New Business in the form of resolutions or comments to be brought before the House before we ask for the report of the Resolutions Committee?

Dr. Latimer: This is a resolution that was brought before Council this morning. I was asked to bring it to the House.

RESOLUTION

Inasmuch as South Carolina possesses a man fully qualified and deserving in all respects of the award, the House of Delegates of the South Carolina Medical Association hereby recommends that all officers of the Association and the delegate to the American Medical Association use every effort to secure the American Medical Association Gold Medal Award for the outstanding general practitioner, for its distinguished member, and former president, DR. W. L. PRESSLEY of Due West.

(The resolution was seconded; there was no discussion; the resolution was passed unanimously, and was so ordered.)

The Chair: Is there any other New Business? Hearing none I will call on Dr. William Weston, Chairman of the Resolutions Committee.

Dr. Weston: I will ask Dr. Price to read the recommendations.

Dr. Julian Price: (Reading)—The Resolution Committee moves the following recommendation of the Committee on Rural Health be adopted:

- Formation of a State Health Council and a County Health Council in each county in the state, sponsored preferably by the local county Medical Society.
- To develop faculty teams at the Medical College to give post-graduate courses over the state directed particularly at the general practitioner.
- To study the advisability and practicability of placing senior medical students or senior internes under the preceptorship of qualified physicians in the rural or semirural areas of the state for a limited time.

The Chair: Is there a second to that resolution?

(The resolution is seconded; there was no discussion and the resolution was voted on and passed.)

Dr. Price: (Reading recommendations of Committee on Public Health and Instruction)

"Change name of Committee on Public Health and Instruction to the "Committee on Public Relations" executive secretary of this committee to be Mr. M. L. Meadors of the State Association."

(This resolution is seconded; there was no discussion; the vote was taken and it was so ordered.)

 $Dr.\ Price$: The Resolutions Committee recommends that

"Agreement be signed with Veterans' Administration, whereby the Veterans' Administration shall deal directly with the State Medical Association, leaving out the present Auxiliary Aid, the S. C. Hospital Service Plan; and also recommend the new fee schedule, as submitted, be adopted."

(The resolution was seconded, there was no discussion, it was voted on and passed.)

Dr. Price: The Resolutions Committee moves that the resolution of the Committee on Medical Service be adopted.

The committee recommends that the House of Delegates "Authorize and instruct conneil to proceed with the further study of the advisability of proceeding with the incorporation of a prepayment medical service plan for South Carolina, in accordance with the laws and regulations applicable and that the members of council be and compose the corporation."

The Chair: Is there a second? (It is seconded)

Is there any discussion? Hearing no discussion we will call for the question. All in favor signify by saying "aye" (There were many "ayes") All opposed signify by saying "no".

(From the Floor)—What was the question?

The Chair: I shall read the question again. The Committee on Resolutions requests the passage of this resolution as a result of the Report of the Committee on Medical Service. (Reading)

Dr. Cain: (Recognized by The Chair) I am not exactly clear about that. I wonder if when the resolution was changed, the House of Delegates be authorized to study it, if they meant to put there that the "members of Council be and compose the corporation."

Dr. Weston: (Recognized by The Chair): As Chairman of the Resolutions Committee I suggest you call on Dr. Guess for an explanation.

Dr. Guess: The Committee on Resolutions took my pencil correction, just before you called on me. The Resolution as I read it is a little bit different from that which you just read, particularly with regard to the point that Dr. Cain is questioning. That is, in changing the resolution, we did not recommend that they proceed with themselves as incorporators. That should be scratched out.

It is simply that Council proceed with the study of the plan in the light of the data the committee is presenting to them, as a part of our report.

The Chair: Dr. Weston, as Chairman of the Committee on Resolutions, will you allow the substitution of the motion that the House of Delegates instruct Council to proceed with the further study of the advisability, etc.

Dr. Weston: We will accept that.

The Chair: Do I hear a second to the substitute motion?

(It is seconded; there was no discussion; it was voted on) It appears the "ayes" have it.

Dr. Price: The Recommendations of the Committee on Industrial Health are found at the end of that report. The Resolutions Committee recommend the adoption of the recommendations as they stand.

(All seven recommendations, are read.)

Those recommendations of the Committee are pre-

sented as a resolution by the Resolutions Committee.
(They are seconded; there was no discussion, the question is put)

The Chair: It appears that it is carried.

Dr. Weston: I move the acceptance of the Committee's Report as a whole.

The Chair: It has been moved and seconded that the Committee report as a whole be accepted with the substitute motion that was earried.

The Chair: Is there any discussion? If not I will put the question, all in favor please signify by saying "aye". Opposed "no". The "ayes" have earried it.

Now, we come to the last piece of business. We will have the report of the Credentials Committee.

Dr. Howard Stokes (Chairman) We ask that Dr. Carl West be allowed the privilege of voting. He is vouched for by the Councilor from his district. There is no other member than Dr. Carl West from Kershaw County here. (This motion was seconded, there was no discussion, it was voted on and earried.)

Dr. Stokes: Mr. President, we had 85 voting delegates.

One of the resolutions you gentlemen just passed entitled Dr. Hugh Smith, delegate to AMA to a vote, so now we have 86 voting delegates.

The Chair: We will now proceed to the election of officers. Under that head comes first the nomination of President-Elect.

Dr. Truluck: As representative of Edisto Medical Society, it is my privilege to present to this body our oldest member, a man who has been practicing medicine 50 years, a man who has been outstanding in the practice of medicine, a man who has attended medical society meetings for years and years, often as a delegate. He has not only been a practicing physician but a leader in his community, in civic, religious and educational organizations. It is my privilege to present to you a man who was practicing medicine long before some of you were born, Dr. A. W. Browning, of Elloree, S. C., a big man from a little town.

Dr. Weston: I second that nomination, it gives me great pleasure to second that nomination.

Dr. Baker: I would like to second Dr. Browning's nomination.

The Chair: Dr. Browning has been nominated.

Dr. Weston: I move the nomination be closed.

Dr. Simpson: I wish to place in nomination the name of Dr. Roderick MacDonald of the 5th District, he is well-known to all of yon, having been actively associated with organized medicine for a number of years. His wide experience in medical affairs makes him the man for the place, his fine record at college, followed by his experience in public health and general practice, and later as an ophthalmologist and otolaryngologist gives him experience in all. He has served on the Council for ten years and for the past two years has served as Chairman; he has given without reservation of his time and energies to the interest of our Association. His experience in the Council has made him currently

familiar with all problems facing organized medicine in the United States and in our home State. His frequent post-graduate courses have brought him in contact with doctors all over the United States with whom he has had the privilege of discussing problems facing organized medicine today. And in the days and years ahead, if there is to be the avalanche of socialized medicine thrust upon us, it is necessary we have someone who is familiar with what has been done and what is to be done. Therefore, I wish to nominate Dr. Roderick MacDonald.

Dr. Wallace: I take pleasure in seconding the name of a man from my neighboring county, Rock Hill. He is a man of high ethical standards, a man who has served our association well and for a long time as member of Council and recently as Chairman of Council. I know of no geographical lines, or qualifications for a president, but we in the section of Rock Hill, certainly deserve some thought and recognition and we know Dr. MacDonald has served this association well and I would like to second his nomination.

Dr. Stokes: I would like to also second Dr. Mac-Donald's nomination.

Dr. Hayne: I have seen him in action in the council, he is now Chairman of the council, he is progressive and relatively young, he certainly seems to be the man for the job that seems to be ahead of us. He is interested in State and financial affairs, he has been prominent in our local and State Society so without any hesitation I second his nomination.

Dr. Hope: It gives me a great deal of pleasure to second Dr. MaeDonald's nomination. I know of no man in this organization who has given more of his time and energy to organized medicine than this man. He is capable, he has had the experience of ten years in Council, two years of which he has been Chairman. I heartily endorse him for President.

Dr. J. R. Young: Mr. Chairman, a few years ago, when this place on the program was reached, our late friend, Lesesne Smith, placed in nomination before the House of Delegates the name of W. L. Pressly. It was my privilege to second that nomination. I made the statement at the time that if the delegates saw fit to nominate and elect him when his term was over there wouldn't be any better loved man in South Carolina than he. I leave it to you to say whether my prophecy was fulfilled.

It is my happy privilege to place in nomination the name of a man I want to make another prophecy about,—if you see fit to make him your president, when his term is over you will agree the society has not had a president who is more interested in organized medicine or has higher ideals of the quality of medical practice. This doctor has demonstrated his interest in that direction, already. He has practiced in this state about 30 years and in his own area of the Piedmont Section of our state. While he is an internist he has been exceedingly interested, (he has not limited his work to his own field.) he has been exceedingly interested in organized medicine and

has done much to raise the standards of medicine in our area. He rendered very fine service on the State Board of Medical Examiners. He has insisted that all men who come before the Board of Medical Examiners be naturalized citizens and Grade "A" men. Dr. George Wilkinson, of Greenville is well-qualified to lead our profession. I gladly place his name in nomination.

Dr. C. H. Blake: I second that nomination. I have known him for a good many years, I have been on the State Board of Medical Examiners with him several years; his ability has never been questioned, his medical ability has never been questioned, he will not compromise anything for the welfare of organized medicine. You will find George Wilkinson standing there shooting, square through the eye. I cannot think of a finer man than he is, I would like to second his nomination.

Dr. Brockman: It gives me lots of pleasure to second Dr. George Wilkinson's nomination. George is my next door neighbor in Greenville and I have beaten on his door trying to get some of these boys in, who maybe ought to help us out a little, and now I see the wisdom of their judgment, trying to keep them out. I want to emphasize what Tom Pitts said, we must back this Board of Medical Examiners, we must keep these boys, these jay-bird fellows out. I would like to second Dr. Wilkinson's nomination.

The Chair: Are there any further nominations?

(Motion is made and seconded that the nominations be closed and this motion was carried.)

The Chair: Gentlemen, we will prepare ballots for Dr. Browning, Dr. MacDonald and Dr. Wilkinson, in the order named.

Tellers: Drs. Billy Smith, Boyd and Gilmore.

Dr. Robert Wilson: We should decide if the high man is to be elected.

The Chair: My ruling is the candidate would have to have a majority of the votes cast, therefore if no one man has more than the other two combined there would have to be a second race.

While the tellers are out I will entertain a motion for Vice-President.

Dr. Lemmon: I would like to place before this body the name of a man, who is a doctor in the true sense of the word, and who, I think, would make a good vice-president, Dr. W. R. Tuten, Sr., of Fairfax.

Dr. Thaxton: I second that nomination.

Dr. Smith: I would like to nominate one of the leading men in our community for vice-president, he is a man who has worked very hard with our local society, he has been president of the District Society, last year, he is very interested in organized medicine and has done a good job, he is the kind of man when you call him will eome anytime. I would like to nominate Dr. Dunean Alford.

Dr. C. J. Milling: I seeond that nomination.

The Chair: Do I hear a motion to close the nominations for vice-president?

(Motion is made, seconded and passed.)

Tellers: Drs. Ike Grimball, Quantz, Robert Wilson, Ir

We come to the election of a secretary. Do I hear any nominations?

Member: I nominate Dr. Price.

From several members-Second, Second, Second.

Dr. Pope: I move the nominations be closed with the Chair casting a unanimous ballot for Dr. Price as secretary.

The Chair: The Chair takes great pleasure in casting a unanimous ballot for our Secretary, Dr. Julian Price.

Now, the office of Treasurer. Do I hear a nomination?

Dr. Price tells me under the Constitution, while the individual can be the same person he must be elected.

Dr. Wallace: I nominate Dr. Julian Price for Treasurer. (This nomination is seconded and a motion made that the nominations be closed.)

The Chair: Are there any other nominations?

Dr. Haynes: (Motion made that the nominations be closed, and this motion seconded, and passed.)

The Chair: I presume that carries that the Chair will east a unanimous ballot for Dr. Price, which I

Gentlemen, we can go on with the election of councilors. The term of Dr. J. W. Chapman expires this year, Councilor for the First District.

Dr. Johnson: The name of Dr. Jeff Chapman is put back up for Councilor for the 1st District, I think he has served the District quite well.

Dr. Brown: Seconds nomination.

Dr. Hope: I would like to place the name of Dr. Archie Baker. He is well-known, and I think he would do this District a good job as Councilor.

The Chair: Dr. Archie Baker has been nominated, is there a second?

Dr. Richard Hanckel: Seconds nomination of Dr. Baker.

The Chair: Is there any other nomination for councilor from 1st District?

I will ask the Chairman of the Tellers to report on the election for President-Elect.

Dr. Billy Smith, ehairman of tellers: In the vote for president:

MacDonald	1	28
Browning		30
Wilkinson		26

The Chair: Since Dr. Wilkinson received the lowest number of votes, you will please prepare your votes for Dr. Browning and Dr. MacDonald.

I will ask the same tellers to act.

We will now hear the report of the Chairman of Tellers, on the vote for Vice-President, Ike Grimball.

Tellers, on the vote for Viee-President, Ike Grimball. Dr. Grimball: Dr. Tuten has been elected Vice-President of this Association.

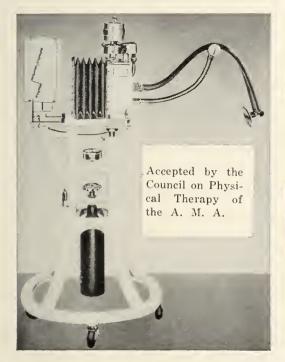
The Chair: I believe we can go on with the election of councilors, the term of Dr. J. B. Latimer, of the Fourth District, expires, do I hear a nomination?

Dr. Jack Parker: We are very happy with our

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councilor and I place in nomination the name of Dr. Latimer to succeed himself.

(Second-Second)

The Chair: Are there any other nominations?

(Motion is made the nominations be closed, this is seconded several times.)

The Chair: Which motion, I presume carries the implication the President cast a unanimous vote for Dr. J. B. Latimer, which I do.

The term of Dr. C. R. F. Baker, Seventh District?

Dr. W. J. Snyder, Jr.: We are very well satisfied with our Councilor and I present the name of Dr. Baker to succeed himself.

Dr. Brockman: I second that nomination.

(Motions made, seconded and passed that nominations be closed)

The Chair: I take pleasure in casting a unanimous vote for Dr. C. R. F. Baker.

The Chair: On the Board of Examination for Registration of Nurses, the term of Dr. L. Emmett Madden expires. I will entertain a motion for one member of the Board of Examination and Registration.

(Motion is made Dr. Madden succeed himself. This motion was seconded and a motion was made that nominations be closed.)

This last motion was seconded and unanimously passed.

The Chair: I take pleasure in casting a unanimous vote for Dr. Madden.

For the Board of Medical Examiners, the Sixth District. The Term of Dr. E. M. Dibble expires this year, do I hear a nomination for Medical Examiner for the Sixth District?

Dr. Haynes: I move that Dr. Dibble be elected to fill the vacancy, I nominate him.

Dr. Stokes: I second that nomination.

Dr. Pitts: I move the nominations be closed. (This is seconded and passed.)

The Chair: I take pleasure in casting a unanimous vote for Dr. Dibble to succeed himself.

Board of Medical Examiners, State at Large-Dr. N. B. Heyward.

Dr. Durliam: It gives me pleasure to nominate Dr. Heyward to succeed himself, he is doing a jambup job.

Dr. Brockman: I second that nomination.

(Motion is made and seconded that nominations be closed.)

The Chair: Since only one man has been put up, the Chair takes pleasure in casting a unanimous vote for Dr. N. B. Heyward.

The next business is the selection of a place for the 1949 meeting.

Dr. Chapman Milling: Columbia most heartily invites this association to meet with us in 1949.

(Clapping)

Dr. II. S. Gilmore: I know that the President of this Association, this year, comes from Columbia, but we, the Pee Dee Medical Society (this comprises (7) counties of the Pee Dee area) will be delighted to have you come to Myrtle Beach next year.

(Hoorays from Delegates)

The Chair: Gentlemen, we have invitations from Myrtle Beach and Columbia. Are there any other invitations? If not, all in favor of Columbia please raise your hands.

All in favor of Myrtle Beach please raise your hands

I think Myrtle Beach has it.

Dr. Smith, Chairman of tellers, will you give us the result of the election of President-Elect?

Dr. Smith: We desire to announce the vote as follows:

MacDonald _____49
Browning ____29

(Applause)

Dr. Wallace: Mr. President, since Dr. MacDonald has been elected president-elect, that leaves a vacancy in the position of Councilor for the Fifth District.

I nominate Dr. C. S. McCants of Winnsboro.

Dr. Haynes: I second that nomination.

(Motion is made and seconded and passed that nominations be closed.)

The Chair: The Chair takes great pleasure in casting a unanimous vote for Dr. McCants.

Dr. Blake: I don't believe we have heard the report of the tellers on the vote for councilor for the First District.

Teller: Dr. Chapman is elected to succeed himself as councilor for the First District.

(Motion is made and seconded that House of Delegates adjourn)

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Looking Backward in Pediatrics-A Challenge For The Future

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Coral Gables, Florida

On this oceasion, when we celebrate the Centennial of the South Carolina Medical Association, it is well to remember the contributions of those pioneers in American medicine who earlier lived in this great State. Many of you have today received an interesting booklet, printing of which was made possible by the courtesy and generosity of Mead Johnson and Company, and which contains excerpts from the Pediatric writings of Lionel Chalmers. Many consider this Charleston physician, who lived from 1715 to 1777, as the first Pediatrician in America. His clinical observations and recommended therapy, as recorded in "An Account of the Weather and Diseases of South Carolina,"1 reveal keen insight and are evidently predicated upon a vast personal experience. The latter portion of his obituary, which appeared in the South Carolina Gazette of May 12, 1777, states that: "he employed the knowledge that he had acquired for the good of mankind, and has left behind him the name of an affectionate husband and parent, a skillful humane physician; and a worthy, honest man." Such a tribute is given to few of any profession. South Carolina may justly be proud of him.

There is a current story about a bird which flies backward; and the reason given for this peculiar mode of flight is that he is not interested in his destination, but merely wants to know where he has been. It might be more appropriate for us to put on our "retrospectacles", consider carefully "where we have been" in Pediatrics; and apply this knowledge in our future progress. Looking backward, then, we may be guided more intelligently in the solution of present and future problems.

Following any war, a period of adjustment is in-

evitable. In our discussion today, emphasis will be placed upon the basic purpose and functions of our profession, as we mention some changes and trends that are developing during the present adjustment era. It is our plan to suggest certain ways in which we can more adequately measure up to our broad responsibilities.

Pediatric service includes much more than the correction of defects and the application of measures for the prevention of infection. The perspective of the Pediatrician should include accurate evaluation of various changes in practice which occur coincident with progress. As far back as 1933, Davison² pointed out that Pediatries has five overlapping functions:

"(1) The care of the newly born, with recognition of jaundice, bleeding, and congenital defects; (2) feeding and diet regulation, nutrition, periodic examinations, the training of infants and children in health habits; (3) immunization against diphtheria, small-pox, etc., as well as the prophylaxis of scurvy, rickets, pellagra and tetany; (4) the recognition of ill children; and (5) the diagnosis, prognosis and treatment of children's diseases, especially during their early and curable stages."

Expansion of this excellent definition of function is now necessary. In the past, the scope of Pediatric service included principally the recognition and correction of defects, the prevention of infection and the treatment of disease. Today, emphasis upon proper growth and development makes it inevitable that the Pediatrician devote a great deal of his time to supervision of the well child. Recently, a review of 1000 consecutive case records during 1946 was made in my office to determine for what reason average parents are now seeking help and advice from the Pediatrician. The results (Table 1) revealed a significant trend toward prevention; with early recognition and treatment of conditions, which generally occur during growth and development of the very young child, constituting a large fraction of

 ⁽Address delivered by invitation at the Centennial of the South Carolina Medical Association—Charleston—May 13, 1948).

the practice. As indicated in the chart (Table 1), this material emphasizes a need for better preventive measures, since about half of the records examined represented problems of sick children. Some significance may be given to these figures because my practice is located in an urban community, with a population of approximately 400,000 people.

TABLE I

CLASSIFICATION OF 1000 CONSECUTIVE CASE RECORDS—OFFICE PRACTICE

	No.
Newborn	81
Well Child Conferences	325
Immunization	104
Sick Children	475
Consultation Diagnosis	15
(Problem Cases)	

The late Franklin Delano Roosevelt listed among the "certain rights which ought to be assured to every American citizen, the right to adequate medical care; and the opportunity to achieve and enjoy good health." Maintenance of present health standards is not sufficient to accomplish this objective. Members of the medical profession, social reformers and the man in the street all agree that something must be done toward improving the health of the population as a whole. Since the recent War, many organizations outside the ranks of practicing physicians have been quoting statistics and have made a variety of recommendations relative to the regulation of medical practice. The Wagner-Murray-Dingell bill proposes to set up a national system of compulsory health insurance to finance medical services for a large proportion of the population through a payroll tax. Under this plan, the individual eould not have free selection of his own physician; and there would be less incentive for the average physician to perform outstanding work in his profession.

In January 1947, Senator Robert A. Taft presented a proposal to the U. S. Senate known as the National Health Bill. This recognizes that personal health is a public coneern; and that those who cannot afford decent medical attention should be helped to get it. But it contends that the local (rather than the Federal) government is the proper administrative agency to provide relief for the needy and indigent. The plan would include allotment of Federal funds to help the States in fulfilling this need; and makes definite provisions for research and inspection.

Public interest in the improvement of child health is rapidly growing. To the physician, it seems a reasonable assumption that better medical care for more children involves a modification of existing programs of medical education and the improvement of facilities for child care. But comprehensive material on which to base recommendations for future action has not been available. The American Academy of Pediatries, in 1944, undertook a nation-wide Survey,

which included four major fields of investigation: (1) general health services; (2) qualification, distribution and activities of professional personnel; (3) hospital facilities; and (4) pediatrie education. Many surveys of child health have previously been made in local areas, dealing with limited aspects of the problem. But never before has there been a similar attempt to gather information pertaining to child health on such a wide scale at one time. One of the fundamental purposes of the Study has been to stimulate local groups to evaluate services for ehild health in their own communities. The magnitude of the task has brought difficulties which at times seemed to be insurmountable. But the sustained interest of a great majority of those who have participated in the work has been heartening. Information has been gathered which will indicate the amount, distribution and character of community health services for children in this country. The study of Pediatric education has given an illuminating picture of training facilities at present available for those physicians who want to equip themselves for the practice of Pediatrics. There is a definite need for translating this fact-finding study into an action program. But it seems reasonable that we, as physicians, should take the initiative, and offer constructive suggestions for improvement of deficiencies that may be found. Better and more practical results would eventually follow an implementation program thus conceived. It should be emphasized that the Study could not have been accomplished by us a group of physicians alone nor by any existing governmental department alone,3 Physicians in private practice, those in academic and hospital administrative positions, dentists, and personnel from established governmental bureaus have worked effectively together in compiling the necessary data. As partial results of the Study are completed, it becames increasingly apparent that the Pediatrician must assume an active responsibility in the provision of better health services and facilities for all children -wherever these are needed.

The Academy's preliminary findings, which were reported by Sisson³ at Dallas in December 1947, are based on the tabulation of data from eight states: Oregon, Montana, New Mexico, Illinois, New Hampshire, Alabama, North Carolina and Maryland. To these were added a hypothetical state consisting of the District of Columbia and two adjacent counties of Virginia (serving as an example of a State essentially metropolitan in character). This group of States represents about 5½ million children under the age of fifteen years, or about 15% of the nation's children. Certain general conclusions can be drawn from this material already analyzed:—

- (1) There is great inequality, both in amount and quality of medical eare received by children in different parts of the United States.
- (2) Children in or near large cities receive more eare than those who do not have access to urban centers.

- (3) The child who lives in a rural area is handicapped by a lack of clinic, specialist and hospital care, and does not have available highly skilled diagnostic and treatment services.
- (4) Existing community health facilities in these rural areas are inadequate to modify the type of school health services. These services are more abundant where more and better child care already exists.

As far back as 1928, Bass4 observed that over 20% of the practice of 150 physicians in general practice dealt with children. Among the eight selected States included in the Academy's preliminary report, 75% of the child care rendered by physicians in private practice is given by general practitioners, in comparison with 12% given by pediatricians and 13% by other specialists. 5 It is evident, then, that better medical care for more children involves pediatric education for the general physician, as well as the specialist. This is definite indication of a trend; and represents only one of several facts gradually crystallizing from the mass of factual data accumulated. The study of Pediatric education facilities has been considered an important part of our investigation since we are convinced that there is little value in planning for more and better health services for children unless consideration is first given to providing well-trained physicians to render those services. Under present circumstances, attempts to strengthen Pediatric education are limited or altogether blocked by the gross inadequacy of financial support for Pediatric education. The cost of medical education to the student is such that he must often terminate his hospital service before he has had opportunity to acquire special post-graduate training in the medical care and health supervision of children. The intelligent solution of this problem challenges the thoughtful consideration of every physician in this country.

A great deal is now known about the medical needs of children in America. In the years to come, it is the hope of the Academy that results of the Survey now being compiled may be utilized to achieve the objectives, which all of us desire, for improving the health of America's children.

Let us consider for a moment some modifications of Pediatric practice which apparently have been a development from the War years. Programs for improvement and maintenance of child health were necessarily affected during that period by the abrupt transfer of many thousands of physicians from private practice to the armed services. The diminished number of physicians in private practice during the actual period of hostilities were confronted with an increased patient load per civilian doctor. This meant greater volume of office and hospital work; and physical inability to study as fully the needs and demands of the individual patient. Children in wartime were subjected to frequent changes by virtue of their role as camp followers. In many instances,

following the War, difficult adjustments and insecurity, associated with a lack of adequate housing, have occurred during the period of rehabilitation, when parents were attempting to start life anew. A comparison of case records from my private practice prior to December 1941 with those after January 1946, reveals a significant increase in functional problems and in deviations from the normal due, presumably, to stress. The importance of this trend is apparent when we consider that normal progress and the development of emotional control determines in large measure, the happiness of the individual, his ability to find a place in the world, and his chance to become adjusted as an acceptable member of society.

The nation needs children who have the ability to withstand the pressures of life. An intelligent understanding of the influence of environmental factors and of emotional adjustment is a necessary reinforcement to the best programs of nutritional care and physical hygiene. Pediatricians can make practical application of this fact in contacts with the youngster, as well as by constructive advice to parents. Interpretation and counsel to provide guidance in home training require the application of tact, intelligence and good judgment. Parents must work out many of these problems for themselves. But the ultimate development of emotional stability and good adjustment to the demands of later life require proper environment and the formation of correct habits during early life. Human relationships are constantly changing, social problems are multiplying; and all of these factors exert a profound influence upon the health and welfare of our children.

Now, what are some of our new responsibilities in Pediatric practice?

The physician requires tact and skill in his contacts with parents as counselor concerning such important daily relationships as the selection of nursery schools, methods of spending recreation time, proper school placement and the correction of faulty environmental factors. Radio programs and movies exert a tremendous effect upon the thinking and behavior of young America. Yet there is no widespread or concerted effort by the medical profession to help broadcasters or motion picture producers in the selection or evaluation of material for presentation. Here is an opportunity for the Pediatrician, as a leader in community life, to influence public opinion; and to render a real service toward improved standards of entertainment.

Good Pediatric practice includes an awareness of friction and tension in the home as a possible clue to certain functional disturbances and behavior problems in the child. The young child is an integral part of the family group; his life experiences are influenced by the attitudes and behavior of those in his immediate environment, especially his mother. We have a definite responsibility to those parents who seek counsel concerning a practical solution to many every-

day problems arising in the lives of their children. The word *practical* is emphasized because these parents have so often become confused by conflicting opinions expressed theoretically by different authors in books dealing with child psychology and behavior characteristics.

Medicine is constantly enlarging its horizons in attempts to provide measures applicable in the prevention of disease. This phase of Pediatrics seems provocative of further careful study in an effort to evaluate the role played by the factors of emotional stress in predisposition to disease.

The modern Pediatrician should be aware of his responsibilities to the community, of which he represents an important part. He should assume leadership in widespread movements that deal with measures for the betterment of children. This will create a greater child consciousness in the minds of all practitioners of medicine; and provide a stabilizing influence for many agencies dominated by non-medical leadership, although dedicated to the problems of child welfare. These lay organizations should have help and active interest from the physician.

The medical profession has not enjoyed good public relations during the past few years; and this situation is due in part to the loss of prestige by the doctor in his community contacts. There is lacking now the position of esteeem formerly occupied by the family physician in the relationship between doctor and patient. In many instances, actual distrust exists. Economic and social progress in the practice of medicine depends upon the sustained interest and effort of individual physicians. Education will overcome many misconceptions and eliminate much of the present antagonism toward us. The position of trust and respect formerly held by the old family physician should stimulate us to renewed efforts for the provision of high standards of proficiency in the practice of the healing art. Good public relations can be very helpful if public support should be needed against objectionable legislation; or in favor of legislation that organized medicine approves. It is possible that some Federal grants-in-aid may eventually be required for financing a constructive program to correct present defects in the quality, amount and distribution of child health services. If so, these funds must be kept out of the hands of professional politicians; and should be controlled in their distribution by others better qualified to maintain high standards of medical service. The influence of every Pediatrician is needed in his home community for intelligent planning and progress.

The logical leader and guide in any effort toward improvement should be the physician. Better medical care for children depends heavily upon the relationship of individual doctors to individual doctors to individual patients. Further progress cannot be made by organization, administration or regimentation. Active participation by medical groups, as well as other organizations interested in the child, is essential for full achievement in programs dealing with these problems. Our responsibility as medical leaders is great. Full utilization of community resources and better interpretation of basic needs can be accomplished by an exchange of information among various organizations and physicians devoting their time and efforts to the problems of children. "The true test of civilization is the kind of man the country turns out," in the words of Ralph Waldo Emerson. Much depends upon what we do for our children in determining what kind of men they will eventually become.6 Let us devote our thought and resources toward an improvement of their future. We will thereby strengthen faith in our democracy. This is the rightful inheritance of the next generation of children.7

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Granuloma Inguinale - Report of 85 Cases Treated With Streptomycin

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South Carolina is classified as a highly endemic area for the fourth venereal disease, granuloma inguinale. Because the treatment of granuloma inguinale in the past, i. e., the antimonial drugs, has offered little encouragement to the patient and his physician, the treatment of this disease has been shifted to the public health clinics and dispensaries where, even though treatment was given free, few patients returned regularly enough to receive an adequate course of treatment. It is the purpose of this paper to report to the practicing physicians what is being done in South Carolina, from the public health viewpoint, in the more recent treatment of granuloma inguinale.

Early in 1947 Greenblatt and his co-workers at the University of Georgia reported rather spectacular results from the use of streptomycin in the treatment of granuloma inguinale. However, the low availability and high cost of streptomycin in South Carolina made impracticable any public health attempt to offer widespread treatment at that time. By January, 1948, the S. C. State Board of Health found it feasible and highly desirable to include streptomycin therapy of granuloma inguinale in the armamentarium of the S. C. Public Health Hospital at Florence and word was sent to the various county health departments that such therapy was available. During the first four months of this year, eighty-five patients have been treated with streptomycin. Of these, forty-five patients have been observed at the end of one or two months' post-treatment period. Consequently it is too early to prepare statistics of the relapse or recurrent rates and this paper is intended to be only an interval report. The immediate results of therapy, however, have been greatly encouraging.

Of this group of patients, forty-nine were females and thirty-five were males, all Negroes, and one white female, age 23. Thirty-four patients had coexistant syphilis for which they were treated concommitantly. Nineteen patients, clinically and serologically free of syphilis, displayed positive skin tests for chancroid or lymphogranuloma venereum. It is significant to note that only in thirty-two patients was there no

elinical or laboratory evidence of veneral disease other than granuloma inguinale.

All three recognized types of lesions of granuloma inguinale were observed in this series, the commonest lesion presented being the ulcerative type of which there were thirty-seven examples. The exurberant form of lesion was seen in thirty-four cases while the cicatricial type lesion, usually in combination with the other types, was observed in fourteen patients. In addition to these, two cases of carcinoma of the genitalia were discovered through biopsy methods after the referring agencies had suspected granuloma inguinale. Fifty-two of the total patients of this group had received some form of specific treatment, i. e. Fuadin or Tartar Emetic, prior to admission but either had not responded to this form of therapy or had become resistant to treatment after an extended period of time during which the lesions failed to heal, or actually progressed in extent despite treatment. Thirty-three patients had received no previous therapy for granuloma inguinale and usually presented histories of lesions of relatively shorter duration than the group with the previous therapy.

A regimen of streptomycin therapy similar to that recommended by Greenblatt was employed in treating this series of patients. Injections of 0.66 Gm. Streptomycin in distilled water were given at four-hour intervals around the clock for a total of twenty grams of the drug. Penicillin-Oil-Beeswax, 400,000 units daily for three days was also given in those cases where secondary infection in the form of fuso spirachetosis was present. All patients with ulcerative or exuberant type lesions were placed on 1:32,000 potassium permanganate sitz baths thrice daily to help combat secondary infection.

Symptoms of eighth nerve involvement from the use of streptomycin were observed in twelve cases. These symptoms were invariably dizziness and tinnitus but were of mild severity only in ten instances. In two cases the severity of reaction was such as to indicate cessation of therapy. Streptomycin was discontinued for forty-eight hours in each case and the course of treatment completed thereafter when the

symptoms of reaction had subsided. No cases of dermatological reactions were observed in this series.

As stated previously, forty-five patients have been observed at this facility one or two months after treatment. Forty of those observed have been completely healed without further therapy of any kind; three patients still exhibited small areas of ulceration that were in the process of healing. Smears for Donovan bodies were repeatedly negative in the latter three cases. One patient, a colored female, showed little evidence of healing after one month's observation and was subsequently re-treated with the same total dosage of streptomycin when smears were positive for Donovan bodies at the end of two month's post-treatment observation. Again there was little evidence of healing and therapy was instituted for the third time three weeks after her second course of streptomycin. Donovan bodies have remained present in all smears taken from this patient's lesions and consequently it was felt that her infection is resistant to streptomycin. One colored male, age 42, has returned six weeks after treatment and Donovan bodies were found in smears from his lesions which have failed to heal. At this writing this patient is still under treatment.

The following is a case history typical of the majority of cases in this series:

Case History:

A thirty-nine year old colored female was first seen at the S. C. Public Health Hospital in January, 1947. On admission she complained of having had genital lesions for the past three years and that she had such a foul odor about her that she was forced to seclude herself in one room of her house. Prior to admission she had been given one injection of 0.6 Gm. neo-arsphenamine, 1 cc bismuth, and one injection (5 cc) fuadin. Her serological test for syphilis was negative.

Physical examination revealed an extremely debilitated, ashen gray, chronically ill colored female who appeared much older than her stated age. Her physical examination was essentially negative except for the extremely foul-smelling, destructive, granulomatous ulcer involving both labia, adjacent perineum and perianal region. Smears taken from the vulvar lesions were positive. She was started on the course of therapy consisting of 5 cc Fuadin daily for fifteen days; however, on her seventh day of therapy she became extremely cyanotic and comatose with respirations shallow and rapid, and B. P. 40/0,

a condition resembling extreme shock. She was revived with Coramine and intravenous glucose. Fuadin was discontinued and two days later the patient was returned home, with the recommendation that her physical condition be improved by other means before endeavoring to give her other courses of treatment. On March 5, 1948, the patient returned to the S. C. Public Health Hospital for a course of Streptomycin. Her general condition was essentially the same as on the previous admission, but the granuloma lesions were more extensive at this time. On March 8, 1948, she was started on a regimen of streptomycin, 0.66 Gm, every four hours for thirty injections, a total of 20 Gm, being given. She was placed on a high vitamin, high protein diet, supplemented by intravenous amino acids. On March 15, 1948, she was discharged with the lesions showing definite evidence of epithelialization.

This patient returned on April 23, 1948, for observation. The area of previous involvement was completely healed with a firm depigmented scar and there was no evidence of progression of the disease. Her general physical condition was markedly improved, the patient's color being normal, her appetite ravenous, and her blood count within normal limits. She was discharged for further observation on April 26.

It will be noted in this case that the disease presented not only a serious threat to the patient's physical well-being but also created an equally serious social problem whereby the patient was unable to live in harmony with her family. Streptomycin therapy has eradicated both of these problems and has allowed this patient to return to her normal social life rapidly. It is felt that in the future all cases of granuloma inguinale should be treated early with streptomycin only, resorting to the other forms of therapy only in those cases where streptomycin fails.

Conclusion

An interval report has been presented on a series of eighty-five cases of granuloma inguinale treated with streptomycin at the S. C. Public Health Hospital. Forty-three of forty-five patients observed after one or two months have shown excellent results. One case of streptomycin-resistant infection has been noted as has one case of treatment failure after one course of streptomycin. A case history was presented of a typical patient showing quick solution of a medical and social problem through streptomycin therapy.

A Ten-Year Maternal Mortality Review-Greenville Hospitals

Jack D. Parker, M. D. and H. M. Allison, M. D. Greenville, S. C.

Since about 58 per cent of the membership of this Association practice obstetrics under similar conditions to those prevailing in Greenville, it is our hope that this review of our mortalities will prove of interest.

Greenville is a city with a metropolitan population of 110,000, surrounded by thickly-settled textile and farming areas. There are two "open-staff," general hospitals, having a 477-bed capacity, neither being connected with a medical college.

This review does not include abortions or ectopics; in fact, with few exceptions, all these mortalities were of a twenty-eight weeks', or longer, period of gestation. During the past ten years, 1938-1947, inclusive, there have been 20,089 deliveries, and, in these, sixty-four mothers have died. This gives an incidence of one death per 314 deliveries. For comparative purposes, this review has been divided into two five-year periods: 1938-1942 and 1943-1947, inclusive. The incidence of death for the first five-year period and the second five-year period compares favorably as 1 to 173 and I to 506 deliveries, respectively, which denotes an improvement of 65.5 per cent. (Table I).

TABLE I

Deliveries 1938-1947 Inclusive	20,089
Maternal deaths 1938-1947	64
Incidence of deaths 10 Years	1:314 or .31%
Deliveries 1st 5-year period:	
1938-1942	6,413
Deaths 1st 5-year period:	
1938-1942	37
Incidence of deaths, 1st period	1:173 or .58%
Deliveries 2nd 5-year period:	
1943-1947	13,676
Deaths 2nd 5-year period:	
1943-1947	27
Incidence of deaths, 2nd period	1:506 or .19%
Improvement in 2nd period	65.5%

Causes of Death

As is apparently customary, the causes of death are divided under four general headings; namely, accidental and coincidental occurrences in pregnancy, toxemias, hemorrhages, and infections.

During the two periods, there was exactly the same percentage of deaths—37 per cent—listed under the classification of accidental and coincidental occurrences. In the first period, 1938-1942, toxemias ac-

Read at the Tenth Annual Meeting of the South Atlantic Association of Obstetricians and Gynecologists, Augusta, Ga., February 12-14, 1948. counted for 35 per cent, and in the second period, 1943-1947, toxemias were responsible for 33 per cent of the deaths. Hemorrhage showed almost double the percentage in the second period as it did in the first period, being 30 per cent and 16 per cent, respectively. Infections were responsible for 11 per cent of the deaths in the first five-year period, whereas, there were no deaths from infection in the second five-year period. (Table III).

TABLE II. Causes of Deaths

198	38-1942	1943-1947
Coincidental and accidental	37%	37%
Toxemias of pregnancy	35%	33%
Hemorrhages	16%	30%
Infections	11%	0%

As is shown in Table III, the deaths listed under the classification of coincidental and accidental causes, show nothing remarkable in the 1938-1942 period, except that six of the fourteen deaths were of thrombotic origin. Three of these were proven by autopsy findings, and the clinical evidence for the diagnosis in the other three cases was definite. Two of the five cases of pulmonary emboli followed cesarean sections, as did the case which died from a mesenteric thrombosis. The case which died from paralytic ileus also followed a classical cesarean which was done on a 31-year-old primipara on account of fibromyomata, and occurred seven days after the operation.

The ruptured uterus death in this period was in a gravida VI who was admitted to the hospital with a temperature of 101.2° F., pulse 156, a foul vaginal lochia, a frank breech, and an incompletely dilated cervix. The patient was given parenteral fluids and opiates, and no immediate attempt at delivery was made. The uterus ruptured in about ten hours, and the patient went into such sudden and profound shock that she died before she could be transfused and operated. Blood plasma was given without any benefit.

The pernicious anemia of pregnancy death was admitted with a red blood count of 1,120,000, and a hemoglobin of 50 per cent. She also had a high fever due to an acute pyelitis. Despite repeated transfusions, she died in two days. This patient, like so many of the others, had had no prenatal care.

In the I943-1947 period, under this same classification, of the ten deaths, two were due to pulmonary emboli. One of these was in a young primipara that occurred less than two hours after an easy, low forcep delivery, following a normal labor. She exhibited marked dyspnoea, cyanosis, shoek, and raised considerable bloody, frothy sputum.

The other pulmonary emboli in this second period was a 37-year-old gravida VIII, in which death occurred four and one-half hours after a spontaneous delivery of a frank breech, following a short, easy labor of only three hours' duration. Dysponea, severe right lower chest pain, and shock were the only clinical signs noted.

The two ruptured uteri that occurred in the second period were both gravida V. One of these was admitted in hard labor with an unengaged head and a history of difficulty with all previous instrumental deliveries. Her attending practitioner felt that she had some type abnormality of the pelvic inlet; just what type was not specified in the chart. An attempt at high forcep delivery was unsuccessful, so an internal version and breech extraction of a stillborn was done. The patient died two days later, and an autopsy revealed a ruptured lower uterine segment with massive intra-abdominal hemorrhage. The diagnosis was not made before autopsy.

The other ruptured uteri was in a patient that had had a long labor at home and attempts at delivery by midwife. She was admitted into the hospital with profuse bleeding, a rapid pulse, temperature of 101° F., an incompletely dilated cervix, and a frank breech presentation. She was given intravenous fluids, transfusion, sedation, and a bag inserted. The patient expelled the bag in twelve hours, and was in very severe shock at this time. She died shortly after. Abdominal exploration revealed a ruptured uterus. It is discouraging that neither of these eases were correctly diagnosed.

There were three deaths attributed to obstetrical shock in the second five-year period, and in two of these, attempts at delivery had been made on the outside by midwives, with histories of very long labors and of shock upon admission. One of these patients died three hours after admission, after having had plasma, blood and glucose and having been delivered by an easy version. The other one died the same day of admission, and three hours after the spontaneous delivery of a full term, macerated breech. This patient also had plasma, blood and glucose. Manual exploration of this uterus immediately after death revealed no rupture.

The third case in this five-year period attributed to obstetrical shock is one who had a normal labor and was prepared for delivery with full dilatation at 4:30 a.m. It was found that she had a deep transverse arrest of the head, and a consultant was called at 6:00 a.m. This consultant was unable to rotate the head and effect a delivery. An obstetrical consultant was then called at 7:00 a.m., and the head was rotated with Kellands forceps, and a live baby delivered without particular difficulty. There was only moderate hemorrhage at the time, but an hour later she had profuse vomiting and showed some signs of

beginning shock, with a blood pressure of 88/52. She was given glucose and plasma at this time, but died in an hour and a half. A postmortem vaginal examination revealed no rupture of the uterus.

The one death listed as due to rheumatic heart disease is of interest in that she had had three hospital admissions due to her eardiac condition, and the last of these three admissions was approximately two months before her admission for delivery. Early in her pregnancy, there was a history of hospitalization due to an auricular fibrillation and decompensation, eventually necessitating an oxygen tent. The second hospital admission was at five months with decompensation, and the third was at six months with an acute left ventricular failure, and she remained in the hospital for a month, under the eare of an internist. Finally, at eight months, her obstetrician admitted her with the intentions of delivering her by cesarean section the following morning. The same evening of admission, she began spontaneous labor, and in three hours had a thin cervix 3 ems. dilated, so it was decided to deliver her from below. There was a chart of an easy, first stage of labor, and delivery was effected by mid-forceps seven hours after the onset of labor. At the time, she had considerable hemorrhage and a lacerated eervix which was repaired. This patient died four hours later due to postpartum hemorrhage, obstetrical shock, and her eardiae eondition. It appears that evidence was sufficient to have warranted interruption of this pregnancy upon her first hospital admission early in pregnancy. However, if the patient had not gone in labor, and the section had been done, the outcome might have been entirely different. (Table III).

TABLE III.

COINCIDENTAL—ACCIDENTAL CAUSES 1938-1942

Pulmonary embolus	. 5
Ruptured uterus	1
Cerebral hemorrhage	. 1
Mesenterie thrombosis	1
Paralytic ileus	1
Baeillary dysentery	. 1
Pernicious anemia of pregnancy	1
Spiroehetal lung infection	. 1
Lobar pneumonia	. 1
Diabetes	. 1
	14

1943-1947

Pulmonary Embolus	2
Ruptured Uterus	2
Cerebral Hemorrhage	1
Obstetrical Shock	3
Coronary Thrombosis	1
Rheumatic Heart	1
· ·	

Toxemia Mortality

Despite the fact that the great majority of maternal mortality reviews, except those from the South, report hemorrhage as the leading cause of death, we find that in this first five-year period, we lost more than twice as many mothers from toxemia as we did from hemorrhage—35 per cent from toxemia and 16 per cent from hemorrhage. In the second five-year period, the percentage ratio of toxemia to hemorrhage is 33 per cent to 30 per cent. The ten-year total: twenty-two mothers lost from toxemia, and fourteen from hemorrhage.

In 1938, the three toxemic deaths, in women of ages nineteen, twenty-two, and twenty-seven years, were all of the severe convulsive type, and two of them were admitted unconscious and never regained consciousness, one dying in eight hours, and the other on the third day. The third case delivered premature twins spontaneously, but died from toxemia eight days later. She had had eclampsia with one preceding pregnancy. None of the three had prenatal care.

As a contrast in ages, in 1939, of the four toxemic deaths, three were of ages thirty-five, forty, and forty-two years. One was para IX, and two para XI. The admitting blood pressures of all three were systolic of 235 or above, and diastolic of 160 or above. One of these died from cerebral hemorrhage and a hemiplegia, and another died in two hours after admission of a cardiac failure. The only young patient this year, a 28-year-old primipara, had a fulminating eclampsia, and died in three days, undelivered. She was the only one of the four that had prenatal care. Three of these four mothers would probably have been saved from their cardio-vascular-renal deaths by previously indicated puerperal sterilization.

One toxemic death in 1940 appears to have been caused by passive prenatal care. She was a 40-year-old para III who had been under medical care for several years due to chronic hypertensive nephritis. She was admitted at seven months gestation, with blood pressure 220/130 and a premature separation of the placenta. A spontaneous onset of labor, transverse position, version and easy extraction followed. She died a few hours later of uremic convulsions.

In 1941, four of the five toxemic deaths were in young primiparae: fourteen, sixteen, nineteen, and twenty-two years of age. All four had severe, continuous convulsions, with marked hypertensions and urinary findings. Three of the four died in twenty-eight, twenty-four, and two hours after admission, and three of the four had no prenatal care. The other toxemic death this year was a 42-year-old para III, who had had a toxemia and section two years before. This pregnancy, twins, was uneventful until near term when she developed a mild hypertension, albuninnria and casts. A low section was done, following which she developed jaundice and clay-colored stools.

and died in eight days. Autopsy revealed a diffuse chronic nephritis, chronic interstitial hepatitis, and splenitis. Hindsight indicates that she probably should have had a tubal ligation at the section two years previously, since she was a 40-year-old toxemic at that time.

In 1942, of sixty-two toxemics, there were no deaths.

In the second five-year period, 1943-1947, there were nine eclamptic deaths, 33 per cent of the total mortality. For the entire state of South Carolina, the toxemia mortality in 1943, was 43 per cent (ninety-five deaths), and in 1944, 34 per cent (sixty-one deaths). Much credit should be given to Seibels and his South Carolina Committee on Maternal Welfare in that the State mortality rate has dropped from 7.7 per thousand live births in 1936-1937, to 2.7 per thousand live births in 1946. As is shown in Table IV, regarding toxemia mortalities in various sections, it appears that the farther North and West one can get from our section, the less chance of toxemia mortality.

Of the nine Greenville cases, eight had repeated convulsions, and only one of the nine was above thirty-five years of age. Six of the nine had no prenatal care, and four of them died in less than twenty-four hours after hospital admission. The lowest admitting systolic pressure was 160, and the lowest admitting diastolic pressure was 110. Four of the nine were admitted with systolics above 200, and six of the nine were admitted with diastolics above 120. Two of the nine had an associated premature separation of the placenta, and exhibited considerable hemorrhage.

In summarizing the toxemic deaths—twenty-two in ten years—it is our opinion that fourteen could probably have been prevented with adequate prenatal care. Only six of the twenty-two death cases—less than one-third—had prenatal care. Five, or 23 per cent, were over forty years of age, and four of these had prior chronic cardio-vascular-renal diseases. Fourteen of the twenty-two were white, and eight were colored patients. In seven of these twenty-two cases, about 33 per cent, there were definite indications that a puerperal sterilization should have been done prior to the fatal last pregnancy.

As Ross so aptly stated in his presidential address before this Association last year, the convulsive paticnt offers no doubt as to the eclamptic state, and the death is recorded as a failure by someone somewhere in the course of the pregnancy. (Table IV).

TABLE IV. - TOXEMIA MORTALITIES

33%
38.5%
32.5%
18.0%
11.1%
10.0%
7.4%
6.2%

Hemorrhage Deaths

Hemorrhage was responsible for 16 per cent of the deaths in the first period, and 30 per cent of the deaths in the second period. Half of the hemorrhage deaths in the first five-year period (three), followed sections, but all occurred within five hours after admission, two of the patients being admitted in shock. With the present blood bank facilities, there is a possibility that all three of these might have been sayed. Two other deaths under this classification had severe toxemia, associated with a premature separation of the placenta, and might more correctly have been classified as toxemia rather than hemorrhage deaths. The other hemorrhage death was probably a placenta previa. She was admitted in severe shock, no history obtainable, plasma started, but she died in less than an hour after admission.

Hemorrhage of the second period accounted for 30 per cent of the mortality, or eight deaths. Three resulted from postpartum hemorrhage; three, placenta previa, two of which were centralis; one, premature separation; and one followed a classical section. Of the fourteen hemorrhage deaths in ten years, five were due to placenta previa, four to premature separation, three to postpartum hemorrhage, and two to uterine bleeding following sections.

In reviewing the possible preventable hemorrhage deaths, it is clearly evident that insufficient blood has been given before most of the actual deliveries. We have been misled by the continuous, incipient type bleeding before delivery, and failed to realize that these patients are on the brink and easily thrown into severe shock from only an average blood loss at delivery. Then, too, there seems to be great variation in individuals as to the degree and length of shock they can stand before irreversible damage has been done, and it behooves the obstetrician to guard against the feeling of too great a security simply because he has blood to give in the event of shock. Several of these deaths forcefully drive home the truthfulness of the old adage of "An ounce of prevention."

Gordon, like others located out of the South, regards hemorrhage as the outstanding controllable factor in maternal deaths, and, from his Brooklyn studies, feels that it has not yielded to preventive measures that can be clearly outlined.

Infection Deaths

In the first five-year period, infection was responsible for 11 per cent of the mortality (four cases); whereas, in the second period, no deaths were due to infection. Three of the four cases in the first period might well be classed under the old phrase, "Danmed if you do; damned if you don't."

One, a 42-year-old colored para XI, was admitted with a temperature of 102° F., hemoglobin 51 per cent, and a blood pressure 182/120, with a shoulder presenting. She was delivered by easy version and

extraction. Her febrile course continued and patient died four weeks later. Autopsy confirmed the clinical diagnosis of hemolytic streptococcic infection which was present on admission.

The second death, due to infection, was a 39-year-old primipara who had a spontaneous delivery, but her temperature at the time of delivery was 99° F. There was a gradual rise, and in twenty-four hours, her temperature was 102° F. She died after a septic course in ten days, and the autopsy revealed death due to septicemia arising from a pelvic peritonitis and an abscess in the cul-de-sac.

The third infection death was a patient who was admitted two weeks after she delivered at home. She had a broncho-pneumonia, temperature of 103° F., hemoglobin 58 per cent, abdominal distention, and a foul lochia. She died the day following admission.

The fourth case was a 17-year-old primipara who was admitted with a temperature of 102° F., a brow presentation with pelvic disproportion, and a history of seventy-two hours of labor at home. She had a live baby, and the attending did a low section. Her chances of survival would probably have been much better with an extraperitoneal section or a hysterectomy after section.

There is a very strong probability that all four of these patients could be saved since the advent of the sulfa drugs, penicillin, and streptomycin.

It is gratifying that no deaths due to infection have occurred in the last five years.

Cesarean Sections

In the five-year period, 1938-1942, ten deaths followed 321 sections, with an average mortality of 3 per cent. At about this same time, Siegel reported an average mortality in Buffalo of 5.1 per cent. It will be noted from Table V that there has been a very satisfying decrease in the incidence of cesarean sections from an average incidence of 1:20 in the first period to an average incidence of 1:46 in the second period. At Duke University Hospital, in 1946, the incidence was 1:96; Emory University Hospital, the incidence was 1:56; and at Roper Hospital, the incidence was 1:21. Our incidence is about an average of these three institutions. Likewise, there has been a very pleasing reduction in a mortality of ten deaths out of 321 sections, to two deaths out of 306 sections in the last five years, bringing the first five-year mortality average of 3 per cent down in the last five years to an average mortality of 0.9 per cent, and the occurrence of no deaths in the last three years, during which time 218 sections were done.

The indications for sections, causes of death, type section, age, and parity have been condensed and presented in Table VI. It was difficult to evaluate some of the indications in the older charts due to a scarcity of notes by the resident and attending staffs, but the charts in the latter part of the review, al-

TABLE V. CESABEAN SECTIONS

Year	Dels.	Deaths	Sections	Incid.	Mort
		1938	8-1942		
1938	920	3	77	1:12	3.6%
1939	1075	2	68	1:15	2.9%
1940	1287	0	61	1:21	0.0%
1941	1407	2	57	1:24	3.5%
1942	1724	3	58	1:29	5.1%
	6413	10	321	Av. 1:20.2	Av. 3.0%
		1943	-1947		
1943	2395	1	38	1:63	2.6%
1944	2359	1	50	1:47	2.0%
1945	2271	0	54	1:42	0 %
1946	3097	0	86	1:36	0 %
1947	3554	0	78	1:45	0 %
	13676	 2	306	Av. 1:46.6	Av. 0.9%

TABLE VI. - CESAREAN SECTIONS

1938-1942					
Age	Parity	Туре	Indication	Death	Cause
31	Primip	Class.	Fibroids	7 Days	Paralytic Ileus
35	Primip	Class.	Pulm. Regurg.	5 Hrs.	Uterine Hem.
34	Gr. VI	Low	Plae. Previa 2 Previous Sees.	4 Hrs.	Hem. & Shock
25	Primip	Class.	"Large Stillborn"	28 Days	Spirochetal Lung Inf.
27	Gr. V	Class.	Pr. Sep. Plac.	5 Hrs.	Adm. in Shock. Hemorrhage
36	Primip	Low	Contr. Pelvis. Trial Labor	2 Days	Pulm. Embolus
42	Gr. III	Low	Toxemia. Twins Previous Sec.	8 Days	Autopsy: Chr. Nephritis & Hepatitis
30	Gr. III	Low	Pl. Previa. Transv. Previous Sec.	4 Days	Autopsy: Multiple Pulm. Emboli
17	Primip	Low	Contr. Pelvis. Trial Labor	6 Days	Autopsy: Mesenteric Thrombosis
17	Primip	Low	Ceph-Pelvie Dis. Brow. 72 Hr. Labor	3 Days	Sepis. Adm. Temp. 102
1943-1947					
26	Gr. VI	Class.	4 Stillborns. 6 Wks. Past Term (?)	1 Day	Uterine Hem.
25	Primip	Low	Plac. Pr. Centr.	12 Hrs.	Hem. & Shoek

though still far from that ultimately desired, show marked improvement. It is worthy of note that five, or almost half of the twelve deaths, died from hemorrhage; that three, or one fourth, died from emboli; and that three had had previous sections. (Table VI).

Conclusion

A comparison of the maternal mortality in the past five years with that of the preceding five years in Greenville Hospitals shows an improvement of 65.5 per cent, or a decrease in mortality from 0.58 per cent to 0.19 per cent. Toxemia is still the leading cause of death, being approximately the same percentage for the two five-year periods. Better active prenatal care, earlier hospitalization and obstetrical consultation, purposed sterilization in indicated cases, and proper dietary regime should reduce this mortality. The review of the deaths due to hemorrhage and

shock indicates that blood has not been given early enough and the patients have not been in condition to stand what might ordinarily be an easy obstetrical procedure. With present blood bank facilities, this seems inexcusable. The mortality rate following cesarean section has greatly decreased, being 3.0 per cent in the first five years, and 0.9 per cent in the last five years, with no deaths in the past three years from 218 sections. A corresponding improvement in the incidence of sections has occurred, showing an average of 1:20 in the first five years, and 1:46 in the last five years.

A standardization of statistical reports on maternal mortality, whereby the same classification is used by various clinics, would make comparisons of some value. The different type cases included, different ways in which the facts and figures are arranged, not only make it difficult, but also very misleading. Such an objective has been proposed by a group of French obstetricians, and it bespeaks an end much to be desired.

Finally, the purpose of prenatal care is safe delivery, and the failure on the part of the patient to seek, or the physician to give, adequate care is largely responsible for our maternal mortality.

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AUGUST, 1948

DEADLINE RAMBLINGS

The twentieth of the month is the deadline for editorials for this Journal. Here it is ten p. m. on the evening of the twentieth and no editorial has been written.

It has been another hot July day with the thermometer pushing its way upward into the high nineties as it is wont to do in the Palmetto state. Patients, those with appointments and those without, have seemed to converge upon the office today—and with the poliomyelitis epidemic prevalent in our sister state of N. C., there is anxiety and worry on the faces of parents of sick little children. The phone has seemed to enjoy its persistent, malicious ringing, and with the usual requests for information and advice have come the sixty four dollar question; "Is it safe for my child to go in swimming in the pool to go to the beach to go to the mountains of North Carolina." To escape it all for a brief spell, we slipped off and took the youngsters, as we had promised, to see Red Skelton in The Fuller Brush Man. And now, in the quiet of the office, we sit at the typewriter to tap out an editorial.

"Why not chuck it all and go on home-nobody reads the editorials anyway." So says the inner man, and we are prone to agree with him. For after all is said and done, there is a large doubt in our minds as to whether these so-called editorials which we struggle with each month ever reach much beyond the eyes of the patient worker in the printing plant who sets them in type. It may be a blow to our selfesteem, but we might as well recognize the fact-few read these bits of writing which come from the mind and the typewriter of the editor. And we cannot much blame those who pass over them lightly with a mere glance at the heading-we would probably do the same thing if we did not enjoy the pleasure of seeing our efforts as they appear on the printed page. Like that one brilliant shot which we make during an afternoon of golf-which stands out in such contrast to those other 94 mediocre strokes—we enjoy reading that small phrase, that single sentence, that particular paragraph over which we struggled and which keeps us plugging along in the hope that some day we will turn out something that might, in its own small way, be termed a bit of real writing.

So casting aside the desire to let this issue of the Journal go to press without an editorial—and the absence of this particular department might well go unnoticed—we begin to search for some subject upon which to write.

The two subjects which we have heard discussed the most in the past few days have been the weather and the coming Presidential campaign. One could write at length about the heat wave which we are experiencing, about the way in which shirts stick to the back, hands become clammy, and sleeping is difficult without an electric fan. But of what value would such a discussion be—there is nothing we can do about the weather, and if we live in this state we can expect such conditions to come each summer.

"Then, how about writing something about the political situation"—the inner man asks. What is there to write? Although as a group, we are not in politics, as individuals we are citizens and voters and are keenly interested in what is going on in the state and national scene. Speaking strictly from his personal interests in medicine, the physician faces a dilemna of the worst type as he proceeds to choose his candidate for President. The Democrats have nominated Harry Truman—an avowed fighter for a federal system of medical care. The Republicans have chosen as their candidate, Tom Dewey, a strong supporter of the present system of medical care-but as his running mate they have selected Earl Warren who has been trying to put over a state system of medical care in California for the past three years. The Dixiecrats have nominated Thurmond and so far as we know at the present time the only plank in their platform is that of opposition to Harry Truman. But what are the views of the Dixiecrats upon the subject of medical care? And finally Henry Wallace presents himself as a candidate for President with views upon medical and social problems which are diametrically opposed to most of those held by the average practicing physician. No, there is little to write about our present national politics which would be either instructive or informative.

How about saying something about our candidates for the U. S. Senate? Upon this subject we might offer a suggestion. In the last issue of this Journal we published the answers which each of these candidates gave to a set of questions dealing with medical affairs. Might we suggest that each physician read these answers before he makes his final choice as to the one for whom he will cast his vote.

"Can't you get away from politics and write about something else?" Yes, we can. Recently we went to Saluda for the annual Pediatric Seminar and we were impressed more than ever with the value of this institution in the field of post-graduate education. Founded by the late D. Lesense Smith of Spartanburg, one of our own, it has become known nationally for its excellence in teaching. Outstanding pediatricians from all over the South come up there each summer, at their own expense, and give of the benefit of their work and their experience as they teach the physicians who come as students. Many of these lecturers enjoy national and international reputations and the information which they give out is the latest word in their respective fields. We have talked with men from various parts of the country and we know of no place where a general practitioner can learn more practical pediatrics in two weeks than he can at Saluda each summer. Under its new Board of Directors and its Dean, Sam Ravenel of Greensboro, the outlook for a bigger and better Seminar in the years to come is bright.

"The weather, politics, the Seminar, you have gotten those out of your system—how about a few words about the one thing that appeals to most of us more than anything else right now—a vacation." We can heartily endorse what every physician says to his patient who is a hard working individual—"You can't expect this old machine to keep on going indefinitely without a rest. Cut loose and take a week or two off and relax. There is no such thing as the indispensible man—your work can get along without you, and you will be that much better when you get back. Pack up your suitease, throw your golf clubs or your fishing tackle in your car—and go."

For the first time since Pearl Harbor we are planning to take the family on a real vacation, without any medical meetings or conferences to disturb the peace. And so we way to those who have been away for a similar experience, we hope that you had as good a time as we hope to have. And to those who have not gone, we say—"you owe it to yourselves, to your family, and to your patients to get away for a while."

The clock has pushed around past eleven and is now wending its way toward midnight, and these ramblings must come to a halt before they become completely incoherent. Perhaps they have become so already. But at least we have finished the editorial before the deadline has been reached and we can sleep in peace—if the telephone doesn't ring.

MEDICAL COLLEGE NEW STAFF MEMBERS IN ANATOMY

The Medical College is to be congratulated on the degree of success in filling the several vacancies in the Department of Anatomy. At the end of this session, with the exception of Associate Professor O'Driscoll, the department was completely empty of staff. Three vacancies had existed for some time.

Dr. Melvin H. Knisely has accepted the Professorship of Anatomy and is now in the process of reorganizing the department, Dr. Knisely was born in Michigan in 1904. He holds a Ph. D. degree from the University of Chicago, For three years he was a Rockefeller Foundation Fellow, serving two years with Professor Bensley at the University of Chicago and one year in Copenhagen, Denmark under Nobel Laureate August Krogh and Professor Paul Brandt Rehberg of the University of Copenhagen. Following an experience in high school and college teaching, he served eleven years in the Department of Anatomy at the University of Chicago, advancing to Associate Professorship, and occupying two years leave of absence in full-time research at the University of Tennessee. He is a member of the Sigma Xi and of the American Association of Anatomists. He has published a monograph on "Selective Phagocytosis" and a number of papers connected with his research, which is broadly in the field of living histology and microscopic pathologic physiology.

His research in alteration of blood and consequent disturbance of circulation under a variety of conditions, presented under the term "blood sludging" is quite outstanding. A report of this work accompanied by remarkable colored pictures was the feature article in the May 31st issue of Life Magazine.

Dr. Knisely will bring the continuation of this important work to the Medical College and will receive full support here together with outside financial aid.

Dr. Henry F. Brooks has accepted the post of Assistant Professor of Anatomy. Dr. Brooks was born in Iowa in 1921. Following his undergraduate degree from Iowa State College, he received the M. D. degree from the University of Chicago, from his connection with which he comes to the Medical College. Dr. Brooks is working with Knisely in the "sludged blood" research, from which he has already made some publication.

Dr. Elsie Taber has accepted the other Assistant Professorship of Anatomy. Dr. Taber is a native of Columbia, South Carolina and is the daughter of Professor Taber of the University of South Carolina faculty. She received her undergraduate degree from that institution, the Master's degree from Stanford University and the Ph. D. degree from the University of Chicago. Following some hibh school and college teaching in South Carolina, she has served as instruc-

tor at the University of Chicago for the past eight years, and became Assistant Dean of Students last year. She is a member of Sigma Xi and other professional scientific societies.

Her research field is in sex hormones, from which she has published several articles.

Associated with this staff also will be Mr. James E. Anliker, as Assistant. Mr. Anliker is a native of Ohio and holds undergraduate and Master's degrees. He has been pursuing the medical course at the University of Chicago, where he has been teaching assistant and he is interrupting this experience to work with Dr. Knisely in phases of "blood sludge" research.

KENNETH M. LYNCH, M. D., DEAN.

NAVY'S NEW MEDICAL TRAINING PROGRAM

The Surgeon General of the Navy has announced the expansion of the Bureau's professional training program for reserve and regular medical officers, which is similar to the recently expanded Army medical training program. The object is to permit more Navy doctors to meet the requirements for certification by the various American Specialty boards, and to encourage the young doctor to intern under the auspices of the Navy. The following are the important points in this program:

Graduates of Class A medical schools who have been accepted for internship by a hospital approved for such training by the Council on Medical Education and Hospitals of the A. M. A. may be commissioned as lieutenants (junior grade), MC, USNR, and permitted to continue their intern training. They will receive all the pay and allowance of the rank while so serving. After completing their internships, the medical officers must remain on active duty for a period of one year. If they meet the professional, physical and moral requirements, they will be given every encouragement to transfer to the regular Navy.

Interns who have completed the one year of obligated service, and who have transferred to the regular Navy, may be considered for residency training on a competitive basis with other officer personnel of the regular Medical Corps.

Resident physicians now in civilian hospitals, or those accepted for approved residency training, are eligible for commissions in the regular Navy. Those so commissioned will be assigned to duty, with full pay and allowances, in the hospital in which they are already a resident, or to which they have been accepted for residency training. Every attempt will be made to permit residents holding commissions in the

regular Navy to complete their training in event of an emergency.

Information concerning any part of the program may be obtained by writing to the Chief of the Bureau of Medicine and Surgery, Navy Department, Washington 25, D. C.

MEDICAL COLLEGE BOARD OF TRUSTEES PUBLIC STATEMENT

"The Board of Trustees of the Medical College of the State of South Carolina, after a period of several years of study and effort has become assured of sufficient financial resources to accomplish the construction and equipment of the essential and long desired teaching clinic-hospital for the Medical College, to provide additional hospital and clinical facilities for the continued operation of a first class medical teaching, training and service center for South Carolina.

"There is in hand a State appropriation of \$3,100,000. Through the State Hospital Plan authorized by the Congress there has been allocated to this project a Federal grant of \$1,550,000, available for use under certain provisions in the period July 1, 1949-52. Charleston County has agreed to provide at least \$350,000 for purchase of the land site. Acquisition of the site and completion of the building plans will apparently occupy the period of time before the Federal grant actually becomes available.

"In the adopted program of the Board of Trustees in connection with the operation of this hospital are provisions designed not only to secure adequate clinical teaching facilities to the Medical College but to protect the interests of the State at large, the medical profession of the community and state and other hospitals of the community and state. In fact the adopted program is designed to give aid to all of these interests. Particularly is the proposed hospital operation to assist practitioners in their problems and not to compete with them. It is designed to receive and to serve patients directed to it by practicing physicians. It is not designed as a free State hospital for operation entirely under State financing on the objectionable state-medicine idea.

"The Board of Trustees is particularly mindful of the importance and value of protecting and preserving the interests of the Roper Hospital for Charleston community service. The Board believes that the continuance of the Roper Hospital in its long and traditional service to the community is of great importance to the Medical College as well as to the community, and will give full cooperation and support to the Roper Hospital so long as it may desire and continue as a complete community hospital service."

THE TEN POINT PROGRAM

M. L. MEADORS, EXECUTIVE DIRECTOR AND COUNSEL

THE PRIMARY AND THE DOCTORS

By the time this appears, the primary in South Carolina will have been held, and, unless the eventful political developments in the state this year result in a drastic change from the customs of the past, our county and state officers will have been selected. In a presidential election year it is difficult to have people like doctors take much interest in local races. Many of us are inclined to look upon them as of lesser importance, simply because the positions which are thereby filled have reference to smaller geographical areas, affect, generally, less people, and carry less salaries than do the positions within the Federal Government.

But we, of all people, who champion States' Rights, should bear in mind the fact that our state officials, including our representatives in the General Assembly of South Carolina, are perhaps the most important of the public servants elected by the people. It is not very reasonable to complain about the ability and intentions of the members of the Legislature, and yet show total indifference to their qualifications at the time when they are being elected. We have undertaken to eall the attention of the members of the Association this year to the importance of their attention to this matter. After the members have assembled in Columbia for the legislative session, and while they are grouped together, the Director of Public Relations acting under a legislative committee and with the help of others. may be able to do something when specific bits of proposed legislation are presented, provided there are reasonable people to deal with. The selection of those representatives, however, is purely a local matter, and one which only the residents of the particular county involved can attend to. It is hoped that some active interest and participation has been exerted this year which will contribute in a real way toward retaining in office the honest, conscientious and thoughtful members of the Legislature, and toward improving the personnel in the case of any others who may not be able to qualify according to such standards.

ACTIVE COUNTY SOCIETIES NEEDED

At several of the meetings connected with the recent annual sessions of the A. M. A. in Chicago, strong emphasis was placed on the importance of the work of the County Medical Society, and its place in the organization of the profession. The morning session of Sunday, June 20th, was devoted to the

subject, and South Carolina enjoyed the distinction of having Dr. Chapman J. Milling, President of the Columbia Medical Society, and one of the Area Chairmen of the National Conference of County Medical Society Officers, as one of the speakers. Dr. Milling gave an interesting account of the methods followed by his County Society in the arrangement and presentation of scientific programs.

Humorous treatment of the relationship between the County, State and National organizations, as "Son", "Dad" and "Grandpa", was given by Dr. F. J. Holroyd of West Virginia, and was highly entertaining and pertinent as well.

That the County Society is the original, basic unit for effective action has long been recognized, but the trouble is that too often, in the smaller centers of population at least, its facilities are not utilized.

In South Carolina, this seems to be one of our main weaknesses. Organizations are not kept intact in some of the counties, and in most of the others, the activities are confined to the monthly or otherwise occasional social and scientific meetings. Between meetings, activities of the County Societies in South Carolina are at a minimum. This should be altered. The County Society as a unit for the promotion of better public relations, for political contacts, is without parallel. And in the medical organization of our state, this potential is almost totally unrealized.

VICE-PRESIDENTIAL CANDIDATE WARREN

Those who look forward hopefully to the advent of a Republican Administration should not lose sight of the attitude of the Vice-Presidential nominee toward state controlled medicine. Governor Earl Warren of California, running mate of Governor Dewey, has for several years been one of the most ardent advocates of a state plan of compulsory health insurance. He has personally sponsored and assumed responsibility for legislation to set up such a plan. So far he has been unsuccessful, but there is nothing in his public utterances to indicate any recent change of mind with respect to this issue.

In the June 22nd issue of the magazine LOOK, Governor Warren set forth how he planned to make his state the first in the nation to "banish the ruinous cost of serious illness." His plan would require all employees to pay one percent of their incomes, up to \$3,000 a year, into a health service fund. The employer would match the contribution of the employee. Benefits under the plan would include "pay-

ment in full of the costs of hospital and laboratory services, with certain reasonable restrictions, and the costs of medical care in hospital cases," and these benefits would be available, not simply to the employees themselves, but to their families also.

In that article, Governor Warren admits the feasibility of the voluntary health insurance plan as a means of cnabling the individual to escape the effects of catastrophic illness. He contends, however, that participation in such a plan requires foresight and that "the hard fact is that they (employees) don't have such foresight."

We could look a long time before finding an expression by a public official setting forth more clearly than does the last quotation above, a paternalistic concept of government. Governor Warren seems to believe sincerely that the welfare of the citizens of the state requires absolutely that provision be made for them by their government because of the absence of judgment, determination or foresight on their part,—the same attitude which he undoubtedly, as a good father, adopted toward his own children.

And another thing to be borne in mind in this connection, are the expressions by Governor Dewey shortly after the nomination, to the effect that it is his intention to make the Vice-Presidency an active and effective part of his administration. He has indicated his plan to have Governor Warren in on the conferences and the decisions on the issues which arise. Choice of the two candidates strategically representing the extreme eastern and western borders of the country is clear enough indication of the important role which Governor Warren is expected to play in capturing the election. The indication is also strong that he will play, if elected, a far more important role than any of his predecessors in the office of Vice-President.

BLUE SHIELD, OR COMPULSORY GOVERNMENT INSURANCE*

Operation of the Conference of Presidents and other Officers of State Medical Societies, Sheraton Hotel, Chicago, Sunday, June 20, 1948.)

The dangers that threaten the free practice of medicine in this country are fast becoming critical, and still we delay in uniting in decisive action to meet them.

We waste precious time in quarreling among ourselves over petty questions of local sovereignty. We amuse ourselves by setting up fantastic straw men, and dissipate our energies in knocking them down, while our enemies have been uniting against us in one national effort. We have thus far done no more than fight a series of rear-guard actions with small unorganized and uncoordinated groups. I know of

no more certain road to disastrous defeat.

Our national leaders seem to be purposefully blind to the social changes that are taking place. It is impossible to halt a movement by merely refusing to recognize its existence; and this movement toward extending the benefits of adequate medical care to all of our citizens has already gained too much momentum to be halted by any means. The last hope of American medicine lies in abandoning our present position in the rear of the column, where we have been holding back, and establishing ourselves firmly in the forefront, where we can guide and direct the movement into paths that are the best for our people as well as best for our profession. I emphasize that the welfare of our people must be given at least as much consideration as the welfare of the health professions. Too many physicians regard medical care as their exclusive prerogative. We must recognize that the consumer of medical care also has a great stake in it; and, if there has existed any doubt as to this, it should have been dispelled by the deliberations of the National Health Assembly, held in Washington early in May.

What can it matter to the participating physician whether the patient pays the bill from his private income, or whether the bill is paid by the medical care plans, so long as the amount paid corresponds with the fee customarily charged in that income level? Even if there is some objection to such a procedure, the alternative is to lose millions of potential patients to employee-benefit associations and medical cooperatives operating their own clinics and hospitals. I cannot stress too strongly the fact that this movement has already reached the point where the medical profession has the choice only of making a reasonable effort to meet the requirements of these large groups of eonsumers of medical care, or of watching the private practice of medicine in this country being rapidly strangled by either cooperative or Government medicine. No other alternatives are left. All other alternatives have been lost in the ten or fifteen wasted years in which organized medicine has pursued an entirely negative course in dealing with this social problem.

Already the United Mine Workers, with 400,000 members, have a 10-cent per ton levy solely for health and welfare. As we assemble here, a union with more than 1,000,000 members is negotiating with a large industrial corporation for a 10-cent per hour increase in wages to be devoted exclusively to a health and welfare program. Another union, with more than 1,000,000 members, has already appointed a medical advisory council to formulate a prepaid health program for its members, to be paid for by a similar 10-cent per hour raise in pay.

Is organized medicine guiding and directing these programs? It is NOT! I happen to know some of the members of this medical advisory council of this gigantic union. I can tell you that they are openly committed to Government compulsory health insurance. Let me give you the names of some of them-Fred Mott, who is directing the Government medicine program in Saskatchewan; Dean Clark, who is director of H. I. P. in New York; Jack Peters, who is Secretary of the Committee of Physicians for the Improvement of Medical Care. I can tell you further that the plan for the medical care of this large union, which was proposed at the first meeting of this medical advisory council, was similar to that of the Health Insurance Plan of New York-the establishment of clinics in every center of this union population, and these clinics to be operated by salaried physicians. This Association is on record as opposing such a plan for medical care.

Why was not organized medicine approached for advice and counsel in the establishment of these huge programs for prepayment of medical care? I'll let you answer that question. But doesn't it shock you, doesn't it give you a feeling of insecurity that the leadership of these great movements, which will exert the most profound effect upon medical practice in this country-that the leadership in these movements has slipped from the grasp of organized medicine? I can tell you that it disturbs me deeply, and that I am convinced that the cause is lost unless you take prompt and effective action to regain control of medical practice in this country. I say "regain" because I am afraid you have already lost it, whether you realize it or not. And you are not going to regain it through the methods you have followed during the past ten vears.

You did me the great honor last year of inviting me to address you at Atlantic City. I spoke to you very frankly at that time, pointing out the dangers to American medicine from within. That the majority of you approved my remarks, and believed in my complete devotion to our medical profession, is indicated by the fact that you have again invited me. I doubly appreciate this present honor; and I am again forcibly reminded of my great responsibility to the medical profession. I shall not, in the slightest, shirk this responsibility nor shall I ever compromise with my obligation to American medicine.

But my heart grows heavy as I see the indifference of many physicians to the threat to freedom in medicine that is becoming more menacing each day; and as I encounter the petty, selfish greed of a few physicians who had rather see the entire structure of American medicine wrecked than to concede one small personal advantage in the general interest.

If we get socialized medicine in this country, it will be organized medicine, and only organized medicine, that has brought this curse upon us. We, as physicians, will have only ourselves to blame. If I were among the group that wants socialized medicine in this country—if I were Channing Frothingham, or Ernst Boaz, or Jack Peters, or Michael Davis, or Isidor Falk—I would not exhaust much energy in making a great personal effort—I would relax and let organized medicine do the job for me. All that is necessary to bring socialized medicine to this country within a very short time is for organized medicine to pursue the same course that it has pursued for the past ten years.

The demand for more comprehensive medical care, and for an effective means of budgeting its costs, has grown, within ten years, from a whisper to a roar. Our people will not be denied much longer. If the medical profession does not at once assume the leadership, if it does not at once cease its double talk and double dealing with the voluntary non-profit prepayment plans, and throw its influence squarely and honestly behind these plans, we are going to have compulsory government health insurance in this country within three years.

I give free medicine a lease on life of three years solely because other heavy financial commitments of the Government will preclude the assumption of the additional burden of compulsory health insurance. The Marshall Plan and the rearmament program will keep the Government, and the taxpayers, strapped for the next few years. But, within three to five years -and I think it will be nearer three-either these measures to restore peace will have been successful, or we shall again be in a war. I believe we shall have peace; and just as soon as the taxpaver is relieved from this terrific burden of his investment in peace, you may be sure the politicians will be ready to impose upon him the burden of a compulsory health insurance program-that is, unless by that time we have demonstrated that voluntary health insurance is a completely satisfactory answer to the problem. And I would emphasize further that, if we start right now, it will take at least two years to effect an organization that can do this job. We cannot afford to waste any more time in fruitless discussions that lead us nowhere. We must decide right now whether we are going to unite in this effort; and, if we are, we must cease all delaying and obstructive tactics.

Don't be lulled into a sense of security by such able studies on socialized medicine as have been made by the Brookings Institution, and the National Industrial Conference Board, and other capable agencies such as these. Of course, every thinking person is convinced that socialized medicine would be a great mistake—a costly mistake both in money and in health. But this issue will not be decided by wisdom. It will be decided entirely by emotion. Like President Coolidge's preacher, who was "agin sin", everyone is against sickness and death. Only a small minority of our

people can understand the dangers of socialized medicine—all they know is that they want everyone to have good medical care, and they are not capable of choosing between the various ways in which medical care can be better distributed. Only a "fait accompli" will convince them—and so we have only a short time in which to show them an accomplished fact.

Don't be misled with such absurdities as the assurance that the Government cannot make you practice medicine if you do not want to. You see what has happened in England. The members of the British Medical Association voted at first to have nothing to do with government medicine. The majority was heavy—80 per cent pledging themselves to remain outside the Government plan. But, as the deadline for participation approached, British physicians by a small majority, voted to accept the government plan.

How long can you hold out in a strike against the Government? How many of you could stick it a year with no income? And how many of you would stick it if you saw a minority group collecting all the gravy? You are trained in medicine. How many of you would be willing to forsake medicine and embark upon another career?

Don't let anyone fool you! If Government medicine comes, 90 per cent of you will be forced by circumstances to accept it, no matter how bitter a pill it will be for you to swallow. So, the only way to prevent this tragedy is to stop it before it arrives—there is little you can do about it after it comes. The medical profession can prevent this tragedy, but only by positive action that will meet the reasonable demands of these large groups. Consistently negative action has brought us to this critical juncture, and has played directly into the hands of the enemies of free medicine. Time is running against us. We cannot longer delay.

GENERAL HAWLEY SOUNDS WARNING

Elsewhere in this department will be found the major portion of an address delivered by General Hawley to the Conference of Presidents and other Officers of State Medical Societies, held at Chicago in connection with the annual meeting of the A.M.A. in June. Had space permitted, we should like to have carried the address in full. It contains strong language, pointed, definite. Some parts perhaps might be justly criticized as exaggerated, but in the main the General's address sounded to us, and still appears on mature reflection after reading it in the calmer atmosphere of a business office, as a courageous, forthright expression by a man in position to know what he is talking about, and whose sympathies and sincerety as a physician cannot be doubted. The

speech so impressed the members of the Conference, including the majority of more prominent Presidents and other officials of State Medical organizations, that a Resolution was adopted shortly afterward requesting that the General be invited to deliver it again the following week before the House of Delegates then in session in Chicago. The request was granted, we are informed, and the General invited to address the House of Delegates—in Executive session.

We are not sufficiently informed upon the plan for Blue Shield, advocated by General Hawley, to express a definite opinion one way or the other. His remarks are carried, and attention called to them to emphasize the opinion of a man of General Hawley's experience and ability on the need for positive, definite action by the medical profession on a nation-wide basis.

MEDICAL LEGISLATION

Two days before the Congress adjourned almost on schedule June 20th, Senator Smith of New Jersey, Chairman of the Sub-Committee on Health of the Senate Committee on Labor and Public Welfare, made an extended report to the Senate on the activities of that Committee during the session, with respect to national health problems.

The remarks of Senator Smith were made in connection with a favorable report by the Committee on Senate Resolution 249, which provides for a continuation of the study of national health problems by the Committee and a report to the next Congress not later than March 15, 1949. The Resolution authorized the Committee, through the Sub-Committee on Health, among other things, to "continue its study of the health problems of the nation and of legislative problems in relation thereto," etc., and such study is intended to be "primarily concerned with ascertaining the full extent and nature of existing national health problems and the action, if any, which the Federal Government should take in relation to said problems."

It is evident, therefore, that although the House and Senate are not in session, activities in connection with proposals for health legislation are by no means at an end.

Senator Smith reported that during the Congress, a total of 27 bills on proposed health legislation had been referred to the Sub-Committee on Health, of which, as he pointed out, S.545 (the Taft Bill), and S.1320 (the Wagner-Murray-Dingell Bill), were the two most comprehensive and the most important. Hearings on these two Bills were convened on 26 different days during the session. In addition, of course, many hearings were held on other measures.

Of particular interest in Senator Smith's report, was the analysis of the results of the inquiry made of the Governors of the States in 1947, as to their

preferences with respect to these two Bills. According to Senator Smith, none of the 48 Covernors favored S.1320, while 25 favored S.545 (the Taft Bill), with or without qualifications. Five were not in favor of either measure, 10 indicated no preference, and 8 Covernors did not report.

The significant feature of this analysis, of course, is the total absence of expressed approval by the Chief Executive of any state for the Wagner-Murray-Dingell Bill. If those who believe in States' Rights can make themselves sufficiently heard, this seems to be a hopeful sign.

Reprinted from the July issue of the Bulletin of the Pee Dec Medical Association.

(Since the above was written, the dramatic announcement by President Truman at the close of the Democratic National Convention, of his call for a special session of Congress, should focus attention again on the possibility of further efforts, even this year, toward enactment of legislation for compulsory health insurance.

(At the moment, the international crisis seems sufficiently grave to warrant claiming all of the attention and the energies which members of Congress may have to spare for legislative activities in the middle of a political campaign. But in a session held at such a time—between the National Conventions and the general elections—amid the unwonted confusion existing this year—anything can happen. The profession and other believers in a Republican form of government administered in a democratic manner had better remain on the alert.

(And after the election—what? Dewey and Warren—Truman—Thurmond—Wallace—that is the field from which our choice must be made.)

FUTURE PLANS OF NATIONAL HEALTH ASSEMBLY ANNOUNCED

Three proposals to implement the recommendations of the National Health Assembly, held in May, were made by its Executive Committee, meeting with Federal Security Administrator Oscar R. Ewing on June 28:

- I. That the Assembly's Executive Committee maintain its own organization as a continuing advisory and coordinating group;
- 2. That the Federal Security Administrator appoint a small working subcommittee to recommend to the full Committee plans on public education relating to health, and on continuing organization and financing;
- 3. That each State be urged to hold a health assembly, patterned after the national Assembly, and giving equal representation to professional and "consumers" groups in order to stimulate the widest possible cooperation among all concerned in health;

that these State conferences endeavor, in turn, to stimulate local conferences along the same line to emphasize and facilitate essential local planning and operation of health services.

To explore practical methods of carrying out the Health Assembly's recommendations, Mr. Ewing will ask the subcommittee to consider:

Publication of the final recommendations of the 14 Sections which constituted the National Health Assembly:

Exploring methods for follow-up and implementation of recommendations made by the Sections of the National Health Assembly—wherever possible, such follow-up should be carried on by organizations already specializing in these fields of activity;

Development of plans and guidance for State and local health assemblies.

REORGANIGATION COMMITTEE COMPLETE

The announcement by Governor Thurmond of his three appointees to the State Covernment Reorganization Committee adds further to the prestige of that already well-constituted body. Those named by Governor Thurmond, as announced on July 22nd, are:

A. L. M. Wiggins, recently retired Under-Secretary of the Treasury, and newly elected Chairman of the Board of the Atlantic Coast Line Railroad, formerly President of the American Bankers Association, and prominent South Carolinian of Hartsville;

Earl R. Britton, constructive and able State Representative of the American Federation of Labor, of Columbia; and Robert McC. Figg, Lawyer, for a number of years Solicitor of the Ninth Judicial Circuit, of Charleston.

The Covernor is to be congratulated on his selections. We do not believe he could have chosen any better.

DEATHS

MARION LEE PEEPLES, SR.

Dr. Marion Lee Peeples, Sr., 77, of Scotia, died on June 16, following a long illness.

A native of Hampton County, Dr. Peeples received his education at Furman University and at the University of Kentucky Medical School. Upon graduation he returned to Hampton County swamp lands where the South Bound Railroad, now the Seaboard Air Line, was being built through the heart of the swamp, and established his practice. With an area of more than twenty-five miles to cover Dr. Peeples was indeed a pioneer physician. But in the highest traditions of his profession he served his people for over fifty years, caring little for his personal comfort as he worked and rode through the long hours of day and night.

More than thirty years ago, Dr. Peeples was active in a project to drain swamps in the area to improve health and farm conditions. He also was instrumental in setting up the first tonsil and adenoid clinic ever in setting up the first tonsil and adenoid clime ever to be held in a South Carolina school house. He did the first socialized medical work in the state through a local volunteer "keep well club" in which each school child paid a small fee for medical care for the school year. Dr. Peeples was the oldest member of Stafford Lodge 216, AFM and an Honorary member of the South Carolina Medical Association.

Survivors include his widow, the former Miss Annie Mason, two sons, Dr. M. L. Peeples, Jr. of Greer, Dr.

H. L. Peeples of Scotia.

WILLIAM ASBURY ROURK

Dr. William Asbury Rourk, 50, died at his home in Myrtle Beach, May 19, after an illness of two weeks. A native of Wilmington, N. C., Dr. Rourk received his education at the University of North Carolina and at Jackson Medical College (Class of 1924). Following hospital training in Philadelphia, he located at Myrtle Beach where he practiced medicine until his death.

Dr. Rourk was held in the highest of esteem by the residents of his home community and was not only medical counselor to them but was a leader in eivie and religious activities. For many years he served as an officer in the Presbyterian Church. He was a member of the School Board of Trustees and served as a member of the first Council of Myrtle Beach following its incorporation. Located at a summer resort he was thrown in contact with individuals from all over the south, many of whom called upon him for medical care. He served all of these so well that he was known and loved throughout the Carolinas.

Dr. Rourk is survived by his wife, the former Miss Gertrude MacDonnell of Philadelphia and one son. James Rodman Rourk of Myrtle Beach.

STONEWALL JACKSON BLACKMON

Dr. S. J. Blackmon, 53, died at his home in Kershaw on June 15.

Dr. Blackmon was graduated from Jefferson Medical School in 1918 and following a year of internship located at Kershaw where he practiced medicine until his death. He was keenly interested in medical organization work having served as President of the Kershaw Medical Society and of the Fifth District Medical Society.

Dr. Blackmon is survived by his widow, the former Miss Melissa Sue Morrison, and by two daughters.

JOHN GREENE PITTMAN, JR.
Dr. J. G. Pittman, Jr., 49 year old physician of Gaffney, died at a Lancaster hospital on May 27, after four days' illness.

In addition to having practiced medicine in Gaffney for a number of years, Dr. Pittman also served in the armed forces during World Wars I and II. In the latter conflict he served as a Captain in the Army Medical Corps and saw considerable action in the European Theatre. He was in several of the hardest battles for France and the low lands, including the Battle of the Bulge.

Dr. Pittman is survived by his wife, the former.

Miss Mary Bailey, and one daughter.

JAMES THOMAS SMITH
Dr. J. T. Smith, 69, of Greer, died suddenly on

May 25, while visiting in Salisbury, N. C.
A native of North Carolina, Dr. Smith was graduated from Emory University School of Medicine. He came to Greer in 1912 where he practiced medicine until his retirement in 1933.

Dr. Smith is survived by his widow, the former

Miss Robbie Hudgens.

Pathological Conference, Medical College of the State of South Carolina

KENNETH M. LYNCH, M.D., PROFESSOR OF PATHOLOGY

ABSTRACT #608

Senior Student E. Y. Smith (presenting):

PRESENT ILLNESS: 61 year old negro man was admitted to hospital on April 17 with chief complaint of "can't move my legs." He dated the onset of his illness to the preceding November when he had rhenmatism in his shoulders and right knee. This improved over a period of weeks. In early December, he began to suffer from pain in his lower back, which was so severe that he had to use a cane. Pain has continued until the present, but seemed to improve, until 3 weeks ago when it began to radiate to the uper abdomen. This radiation of the pain was accompanied by the increasing inability to void and to defecate. His abdominal wall became weak. The weakness of his legs increased and 4 days before admission had progressed to complete paralysis.

PAST HISTORY: No history of positive blood Wassermann or antiluetic therapy.

PHYSICAL EXAMINATION: T 101, P 100, R 20, BP 145/80. Patient well developed and well nourished, acutely ill, lying in bed on his back and unable to move his legs. Alert and cooperative. Extraoecular movements to normal. Pupils equal and react to L & A. Ears normal, teeth carious. No enlarged lymph nodes. Neck supply. Thorax expanded equally. Questionable dullness at base of right lung. Heart: PMI in 5th intercostal space 9 cms. from midsternal line. No murmurs. Rhythm regular. Abdomen: Liver not felt. Spleen not palpable. No other masses, no tenderness. Decrease in musele tone over abdominal wall. Genitalia normal. Rectal sphincter tone poor, otherwise negative. Prostate not enlarged. Small nodule felt on left inferior portion. Complete loss of motor power and diminished to absent sensations of all types from level of T 10 downward. Knee jerks were hypoactive, ankle jerks absent and Babinski negative bilaterally. There was tenderness over the lower thoracic and 1st lumbar vertebra. Light percussion below over T 10 caused shooting pain of girdle type.

ACCESSORY CLINICAL DATA:

4/17-Urinalysis. Sp. Gr. L012, alb. 2+, WBC-

4 HPF.

5/10-Sp. Gr. 1.014, alb. 2+, sugar 2+, WBC-20 HPF.

4/17-Blood. RBC 3.22 million, WBC 6,050. Hemoglobin 8 gms. PMN 72%. Lymphocytes 1%.

4/23—WBC 9,700, hemoglobin 9 gms. PMN 72%. Lymphs 25%. Urine neg, for Bence-Jones protein.

4/18—Urea nitrogen 17 mgms. %. Acid phosphatase .6 units. Alkaline phosphatase 5.4 units. Lumbar puncture.

4/18—Opening pressure 170. No rise with compression of jugular veins. Only 8 cc. of fluid obtained. Fluid clear and colorless. Closing pressure 0. Cell count 17, 98% lymphocytes, 2% polys.

X-rays available.

COURSE IN HOSPITAL: Patient seen by numerous consultants. The urologist reported that the prostate was normal in shape and size. The orthopedists found tenderness over lower thoracic and lumbar spine on deep palpation. No deformity of spine. His temperature continued to spike to 101 and 102, occasionally reaching 103. On 4/20 the patient was transferred to surgery and on 4/22 a laminectomy was performed at the level of T8 and 9. The dura was incised and a catheter inserted in both directions in the epidural space. On 4/24 patient had some return of sensation in lower extremities, being able to tell which leg was touched. Oceasional contraction of lateral thigh muscle occurred. Developed extensive decubitus ulceration. On 7/15 patient began to have considerable difficulty in breathing with a respiratory rate of 40 to 50 per minute and many rhonchi in chest. Lungs dull to percussion and filled with moist rales. Thoracentesis on 7/16 yielded 450ce. of dark brown fluid. Patient became irrational, then comatose, and died on July 19.

Dr. F. E. Kredel Conducting: Mr. Howell, will you discuss the case?

Student R. A. Howell: The complaints of pain, weakness, and paralysis of both lower extremities make one think of compression of the spinal cord, which may be due to a primary or secondary lesion, or due to compression of the cord by the vertebral column proper. In considering the various tumors, one would have to consider the extramedullary and intramedullary types. In the extramedullary tumors the onset is usually that of root pain, whereas, in this case, the pain was localized to the lower back. Likewise, extramedullary tumors usually involve sensory tracts in the ventro-lateral aspect of the cord and cause loss of sensation in the opposite side of the body. This patient had bilateral sensory loss. In addition, extramedullary tumors usually produce spastie paralysis on the same side. This patient had a flaeeid paralysis bilaterally. According to the history there must be pressure on both sides of the cord and a rapidly progressive lesion. Complete block of the subarachnoid

space as noted on lumbar puncture is further evidence of the extent of the pressure. Extramedullary tumors usually do not block off the subarachnoid space completely and usually give rise to the girdle type of pain. An extramedullary tumor doesn't fit the picture completely, because of lack of root pain and rapid loss of sensation and motion bilaterally. Exceptions would be very rapidly growing extradural sarcomatous types of lesions. It should also be recognized that this picture could be produced by collapse of the vertebral column. One must also consider secondary tumors of the cord. In view of the prostatic nodule noted by one observer, this idea must be given further consideration. In addition, some other silent primary tumor, perhaps originating in the kidney, must be thought of. The urological report is not sufficient to rule out primary carcinoma of the prostate, particularly as no mention of the consistency of the gland has been made. Another possibility is multiple myeloma. This is mentioned despite the report that the urine is negative for Bence-Iones protein.

Dr. Kredel: How reliable is the Bence-Jones protein test?

Student Howell: The presence of Bence-Jones protein is of importance as confirmatory evidence. Its abscence is not of much significance.

 $Dr.\ Kredel$: What other causes of vertebral collapse are there?

Student Howell: Senile osteoporosis and Paget's osteitis deformans. This patient also presented a terminal picture of pneumonia which, together with the presence of chest fluid, could well hide the presence of a metastatic earcinoma of the lung. Perhaps there was a primary carcinoma of the prostate with metastases to the lungs and vertebral column. Further consideration might be also given primary carcinoma of the lung. In summary, my impressions of this case are, first, this patient has carcinoma of the prostate with metastases to the vertebral bodies, and second, carcinoma of the lung with metastases to the vertebrae.

Dr. Kredel: Are you interested in the X-ray pictures?

Student Howell: Yes, sir.

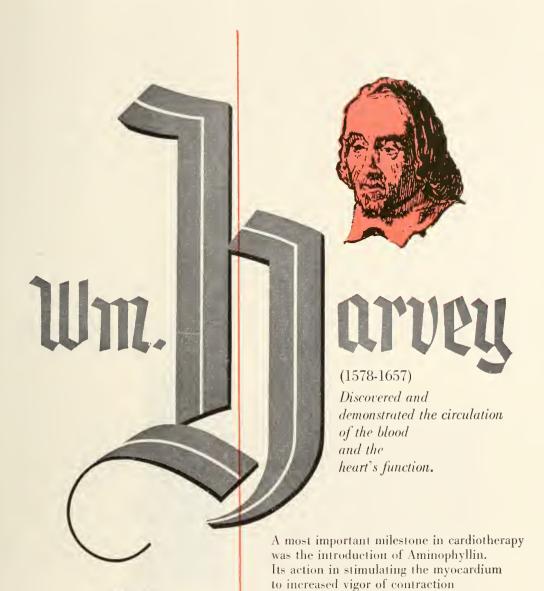
Dr. Kredel: Will you please examine the X-ray films while Mr. Mood continues the discussion?

Student Mood: I agree with Mr. Howell in believing that this patient had carcinoma of the prostate. It is not unusual for symptoms to arise from metastatic carcinoma before the primary site is discovered. What was the consistency of the prostate?

Student Smith: The prostate was said to be normal in size and contour and rather flabby.

Student Mood: I would also consider extra—and intramedullary tumors, especially of chorda equina.

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Dr. Kredel: Where does the chorda equina begin and end?

Student Mood: The chorda equina begins at the level of the first lumbar vertebra and extends distally.

Dr. Kredel: This patient's level is at T 10.

Student Mood: The tumor might well have extended upward. In addition, one should consider tuberculous process involving the vertebral column, but Pott's disease of the spine should be readily detected on X-ray.

Dr. Kredel: Are any other infections diseases to be considered in this instance?

Student Mood: None, localizing in this area.

Dr. Kredel: Your impression then is carcinoma of the prostate with metastases to the vertebral column? Student Mood: Yes, sir.

Dr. Kredel: Mr. Perry, please consult with Mr. Howell on the x-ray findings. Will you comment further?

Student Perry: My first impression also is carcinoma of the prostate with metastases to the vertebral column. Hodgkin's could possibly give this picture, but one would expect earlier signs such as widening of the mediastinum. One should also consider tuberculosis, but this should occur at an earlier age. Did this patient have any serological test while in the hospital?

Student Smith: Blood and spinal fluid Wassermann

were negative

Dr. Kredel: How would syphilis account for this picture?

Student Perty: Most likely by a gummatous process exerting pressure on the spinal cord. My final impression, however, is a malignant process, most likely primary in the prostate, with metastatic extension to the vertebral column.

Dr. Kredel: Mr. Howell, what do you note on the X-ray films?

Student Howell: These X-rays will rule out multiple myeloma in my mind. The chest X-ray shows an apparent mediastinal mass extending laterally into the hilum. There is also an increased density of T 12 and L 1. These latter findings are consistent with carcinoma of the prostate.

Dr. Kredel: What rae these varying areas of density in the left ilinm?

Student Mood: These could well be accumulations of gas?

Dr. Kredel: What else do you note on the flat plate of the abdomen?

Student Howell: There are large accumulations of gas throughout the intestinal tract, particularly the small intestines.

Dr. Kredel: What is the significance of this?

Student Howell: This would be consistent with a



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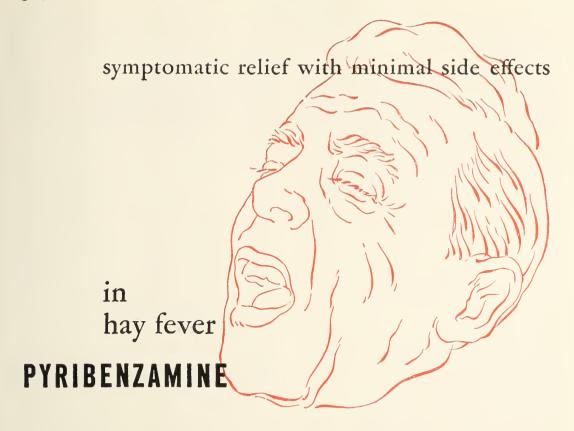


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carcinoma of the right side of the colon with obstruction and distention proximally.

Student Mood: The intervertebral discs of T 7, 8 and 9 are narrowed.

Dr. Kredel: Thank you, gentlemen. Are there any further comments from the students or the faculty?

Dr. Camberlain: I do not completely agree that there were no typical sensory changes in this picture. Disturbances of sensory sensation began when he had to use a cane. Although not expressed as such, these might have been girdle like, at any rate he had to use a cane in an attempt to splint himself. This continued until the time of admission when he presented a picture of a transverse myelopathy or compression myelopathy. I had also wondered about the results of the serologic tests. One must definitely consider earcinoma involving T 9 and 10 with a complete compression and loss of function below.

Dr. Kredel: Can anyone of the faculty discuss the value of the Bence-Jones protein test?

Dr. Ellis: My impression is that the presence of Bence-Jones protein is good confirmatory evidence, but its absence is of no value.

Dr. Kredel: I was wondering how many cases of multiple myeloma produced Bence-Jones protein. The figure of 60% comes to my mind.

Student Dennis: Boyd says 50% do not produce Bence-Iones protein.

Dr. Kredel: To complete the discussion of this case one should also consider vascular disorders. The picture is slow for thrombosis, but one must also consider aneurysms, particularly dessecting aneurysm of the aorta. However, here again the course is against it. I feel that this is an unusual picture for carcinoma of the prostate. The only favorable feature in my mind is the sclerosis noted in T 12 and L 1. Besides metastatic carcinoma of the prostate usually involves the pelvic bones first. Furthermore, I do feel that it is too common for carcinoma of the prostate to metastasize to the lungs. You are quite right that symptoms from metastatic prostatic carcinoma may be noted without any clinical evidence of the primary neoplasm.

Dr. McIver: I do not feel that it applies particularly in this case, but for the sake of completeness it might be well to also include certain dumbbell shaped neurofibromata which arise in the mediastinum and extend through the foramen.

Dr. Kredel: I don't feel that the usual configuration is consistent with the X-ray picture.

Dr. McIver: I agree and am merely offering this suggestion to complete the differential picture of mediastinal masses.

Dr. Kredel: Dr. Cannon will present the pathological findings.

Dr. W. M. Cannon: Final Pathologic Diagnosis: Liposarcoma of Mediastinum with Metastases to Pleura, Liver, Dura and Vertebrae with Muelomalacia of Spinal Cord.

This is a rare lesion which we have not encountered in this location in previous necropsies performed by this Department. Liposarcoma is not rare in other locations, but is decidedly uncommon as a cause of the clinical course presented here.

Decubitus ulceration and emaciation were the prominent external features.

Upon removal of the right lung a mass of soft yellow tissue 10 cm. in diameter was found atop 7th, 8th, and 9th thoracic vertebrae in the posterior and inferior part of the mediastinum. It extended into the right pleural cavity, so that this cavity was in large part filled with soft, yellowish, cystic tissue. Posteriorly it infiltrated the vertebrae which it overlay and the spinal cord in this area was soft and putty-like. Neoplastic nodules were present on the surface of the spinal dura as well as within it, but there was no actual neoplastic invasion of the cord proper.

Within the dome of the right lobe of the liver was a large tumcfaction composed of soft, smooth yellow tissue, in other words resembling fat.

Microscopically the tumor cells were markedly pleomorphic and had vacuolated evtoplasm that was strongly positive for fat with special stains. In a few places the tumor produced a fairly well differentiated type of adipose tissue.

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ABSTRACTS

Smithy, H. G., Pratt-Thomas, H. R., and Deyerle, H. P.: Aortic Valvulotomy Surg., Gynec., & Obs. 86, No. 5, May, 1948.

A description of two methods of performing aortic valvulotomy was presented comparing results obtained by the two procedures.

The first method consisted of passing a specially devised valvulo tome retrogradely through the ascending aorta engaging a sliding barbed blade on a leaflet of the valve. The second method which proved safer, simpler and more effective than the first consisted of division of one or more valvular leaflets by approaching the aortic valve through the wall of the left ventricle. Detailed description of the operations with illustrative drawings, illustrations of valve defects obtained microscopically and grossly, and electrocardiographic tracings was presented.

The mortality of the 37 dogs subjected to the transacrtic route was 27 percent; however, among the 7 animals in which direct suture of the defect was done, there were 5 deaths due to severe hemorrhage. Of the remaining 30 dogs there were only 5 deaths with a mortality rate of 17 percent after revision of the closure of the acrtic wound.

Examination of the heart in the 27 surviving animals showed no lesion in 3 dogs. Either perforation, laceration, partial avulsion, or division of the valve with ausculatory murmurs were found in those remaining.

Of the 15 dogs undergoing transventricular valvulotomy there was only one death due to acute dilatation of the left side of the heart immediately after complete division of an aortic leaflet. Another dog died of acute purulent pericarditis and empyema on the seventh postoperative day. About 2/3 of the dogs showed marked disturbance of rhythm during manipulation of the heart. Return to normal rhythm was prompt following manipulation. In all of these animals there was sufficient division of the valve to produce aortic regurgitation.

The authors believed that the transventricular approach with an improved valvulotome, which would remove a segment of the valve rather than divide or lacerate it, would provide adequate means of increasing the size of a narrowed valvular orifice due to previous disease, thus relieving stenosis but producing a less serious regurgitation. The disturbance in rhythm would be combated with quinidine sulfate given preoperatively and the topical application of procaine at the time of operation.

This procedure is applicable to mitral as well as aortic stenosis.

White, J. C.: Procaine Block of the Sympathetic Nerves in the Study of Intractable Pain and Circulatory Disorders, Surg. Clin. N. America, October, 1947, pp. 1263-1280.

The diagnostic injection with procaine of various parts of the utonomic nervous system has lead not only to accurate diagnosis and in many instances, to the accurate prognosis to be expected from surgical treatment, but also gives the patient a demonstration of what can be accomplished by the proposed operation.

The technique for temporary block using novocaine is described. Examples of the conditions in which paravertebral block for visceral pain has been most helpful are: severe angina pectoris, painful aneurysms of the aorta, cancer of the upper abdominal viscera, penetrating duodenal ulcer (in patients with advanced coronary disease), postoperative narrowing of the biliary ducts, and pancreatic calculi.

The intense discomfort of causalgia, post-traumatic arthritis with osteoporosis, and the diffuse aching or burning pain which sometimes follows peripheral amputations in individuals with chronically cold and sweaty extremities can often be relieved, sometimes permanently, by paravertebral procaine block. Sympathetic block in this group of neuralgias must give complete relief of pain before a sympathectomy can be considered of value. In the cases in which dignostic block has been followed by no response, sympathectomy is not likely to succeed.

Procaine block to paralyze the sympathetic vaso-constrictor impulses has been found to be of value in diagnosis and prognosis in Raynaud's disease but less valuable in thromboangiitis obliterans and arterio sclerosis. While 90% of patients with obliterative vascular disease in whom the popliteal pulse is present will show a rise in temperature of the foot following paravertebral or spinal block, when popliteal pulse is absent, the majority will have no post-injection rise. However, some 40% of this group will have a good response following resection of the 3 upper lumbar sympathetic ganglia. It is evident that a vasoconstrictor block of short duration does not permit full development of blood flow through patent small collateral vessels.

Cases representing the above disorders who were relieved by paravertebral block and sympathectomy are presented.

Eiseman, B., Seelig, M. G., & Womack, N. A.: Talcum Powder Granuloma: A Frequent and Serious Postoperative Complication. Ann. Surg. Vol. 126, No. 5, 820-832, Nov. 1947.

A review of 37 cases of talcum powder granulomas producing symptoms serious enough to require admission to Barnes Hospital for treatment is presented.

These cases present a wide diversity of complications ranging from simple wound abcesses to serious sequelae, such as fecal fistulae and intestinal obstruction. A review of the literature reveals numerous similar cases reported.

Talcum powder contamination of wounds seems to come as a result of (1) outside powdering of surgeon's gloves, (2) the practice of allowing talcum to be placed on the scrub nurse's table. (3) the spread of powder throughout the room, due to the vigorous powdering of hands preparatory to donning gloves. (4) escape of powder from torn gloves during the operation. (Weed and Groves found that in 74.4% of all operations, at least one of the gloves used by the operating team was torn, and of all gloves examined, 22.6% showed perforations after operation.)

The clinical and pathological nature of talcum powder granuloma is discussed in detail.

Emphasis is placed upon the requirements of suitable alternative dusting powder for use in operations. The best answer to the problem is believed to be the use of wet gloves or the substitution of an innocuous dusting powder. Potassium bitartrate, properly sterilized, can be used. Starch, treated with formaldehyde. was found by the authors to be non-irritating to the tissues, but the compounds are not stable and must be modified before it can be recommended. Talcum powder itself must be banned from the field of surgery.

WOMAN'S AUXILIARY SOUTH CAROLINA MEDICAL ASSOCIATION

President: Mrs. P. M. Temples

Publicity Secretary: Mrs. William H. Folk

REPORT OF ANNUAL CONVENTION OF THE WOMAN'S AUXILIARY TO THE AMERICAN MEDICAL ASSOCIATION IN CHICAGO, ILLINOIS JUNE 21-25, 1948

Headquarters of the Twenty-Fifth Annual Meeting of the Woman's Auxiliary to the American Medical Association was the Hotel LaSalle in Chicago, Illinois, June 21-25, 1948.

On June 21 in the Century Room at the Hotel La-Salle a tea was given in honor of Mrs. Eustace A. Allen, President, and Mrs. Luther H. Kice, President-Elect. Hostesses were Auxiliaries to the Illinois State Medical Society and to the Chicago Medical Society.

A luncheon in honor of the Past Presidents was held on June 22. Dr. Morris Fishbein, Editor, Journal of the American Medical Association and Hygeia, was the guest speaker. The sum of \$400.00 was given by the American Medical Association in eash prizes to the Auxiliaries obtaining the largest number of subscription credits to HYGEIA during the Contest September 1, 1947 through January 31, 1948.

Members of the Auxiliary and guests were invited to the Opening Meeting of the American Medical Association, Grand Ballroom, Hotel Stevens, at 8:00 P. M. June 22, 1948.
At 12:30 P. M., June 23, the Annual luncheon in

honor of the President and President-elect was held. Mrs. Rollo K. Packard, Past President and Conven-tion Chairman, presided. Guests of Honor were Dr. Edward L. Bortz, President, Dr. R. L. Sensenich, President-elect, Dr. J. J. Moore, Treasurer, Dr. George F. Lull, Secretary and General Manager, Dr. Morris Fishbein, Editor of the Journal and Hygeia, and members of the Advisory Council.

The Annual Dinner of the Woman's Auxiliary for members, husbands and guests was enjoyed in the Grand Ballroom at 6:30 P. M., June 24.

Believing that wives of medical men, who have

dedicated themselves to serving mankind through the ART OF HEALING, are a link in the chain of the Medical Family, members of the auxiliary paused for self-evaluation and re-dedicated themselves for their place beside them.

Chicago is a City of Unforgettable Memories and the Annual Convention was a success.

WOMAN'S AUXILIARY TO THE COLUMBIA MEDICAL SOCIETY

The Woman's Auxiliary to the Columbia Medical Society cooperated with the City of Columbia in its campaign for supplies for its adopted French town, Berck-sur-Mer, by being responsible for supplying the needs of the Maternity Ward of the French town's hospital. Contributions were entirely voluntary and over seventy members of the Auxiliary were active participants. Mrs. A. F. Burnside, general chairman of the drive, reported twenty-two boxes of supplies collected and packed by her committee. Bed-jackets. gowns, infants wear, soap, powder, oil, knives, forks, spoons, and all other essentials for a maternity ward were included. A sum of \$56.00 was donated to purchase additional supplies and \$25 and six bolts of sheeting were contributed to the Maternity Ward collection from the general campaign fund of the City of Columbia. Auxiliary members on the committee assisting Mrs. Burnside and her co-chairman, Mrs. Kirby D. Shealy, were: Mrs. B. D. Caughman, Mrs. Robert E. Seibels, Mrs. R. L. Sanders, Mrs. Rudolph Farmer, Mrs. Robert B. Durham, Mrs. Hugh Wyman, Mrs. B. H. Baggott, Mrs. Marion Hook, Mrs. R. Wilson Ball, Mrs. J. A. Fort, Mrs. Joe E. Freed, Mrs. H. L. Timmons, Mrs. W. A. Hart, Mrs. William Weston, and Mrs. L. Emmett Madden.

> WOMAN'S AUXILIARY TO THE SPARTANBURG COUNTY MEDICAL SOCIETY

Members of the Woman's Auxiliary to the Spartanburg County Medical Society honored high school seniors from Spartanburg and Spartanburg County who were interested in Nursing as a profession with a tea at the City Recreation Center.

The President, Mrs. John Watkins, and members of the Nursing Committee greeted the guests at the door. The Nurse Recruiting Committee was composed of the following: Mrs. I. A. Phifer, Chairman, Mrs. James D. Nelson, Mrs. D. C. Alford, Mrs. George W. Price, Jr., Mrs. Sam Black, Jr., Mrs. W. C. Wallace and Mrs. Furman Wallace. Mrs. John Shirey served as Chairman of the Nurse Recruitment Poster Committee.

Mrs. Watkins introduced Miss Hazel Williams, Supt. of Nurses, Spartanburg General Hospital and she spoke briefly and sincerely to the high school



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BIBLIOGRAPHY: 1. United States Dispensatory, ed. 21 Philadelphia, J. B. Lippincott Company, 1947, p. 1446, 2. Wieshader, H., and Filler, W.; Am. J. Obst. & Gynec. 51:75, 1946, 3. Allen, W. M.; South, M. J. 37:270, 1944, 5. Lyon, R. A.; Am. J. Obst. & Gynec. 47:532, 1944, 5. Groper, M. J., and Biskind, G. R.; J. Clin, Endocrinol. 2:703, 1942, 6. Soule, S. D.; Am. J. Obst. & Gynec. 45:5315, 1943.

*1

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seniors about the advantages of a Nurse's Education.

Miss Williams presented Miss Peggy Genoble of the Pacolet High School the first prize of \$10.00 given by the auxiliary for the best essay on "Why I Should Like to Become a Nurse".

Miss Williams also presented two student nurses from the Spartanburg General Hospital who had been speaking to high school seniors throughout the county during our Nurse Recruitment Campaign.

Miss Pearl Gaston, Supt. of Nurses at the Mary Black Clinic, awarded the second prize of \$5.00 to Miss Marjorie Wallace from the Spartanburg Senior

High School.

After the tea the seniors present were carried on a tour of the Spartanburg General Hospital and the Mary Black Clinic.

CORRESPONDENCE

July 3, 1948

Dr. Julian P. Price, Editor South Carolina Medical Journal Florence, S. C. Dear Dr. Price:

This is to see if you can advise us in contacting a young doctor to serve our community. There are approximately 5,500 people in our area that arc without medical treatment.

At the present time we are constructing a ten-bed hospital with X-Ray unit, delivery room, operating room, doctor's office, examination room, and laboratory facilities. We also have a first-class prescription drug store adjacent to the hospital.

We prefer a young doctor who is married, and would like to settle down with us. There is a large lake here, which is well stocked with fish, with nearby mountains to add to the scenic beauty. All of our roads are easily accessible by car during the wet seasons

If you know of any young man who might be interested, please have him contact me.

Yours very truly
J. L. Hooper, Jr.
Towns County Hospital Authority
Hiawasse, Georgia.

THE VARNVILLE RURITAN CLUB VARNVILLE, S. C. July 2, 1948

Dr. Julian P. Price, Editor, South Carolina Medical Journal,

Florence, S. C. Dear Dr. Price:

Recently we wrote the S. C. Medical College in Charleston, S. C. relative to assisting us in obtaining a Medical Doctor for this area. We have just received a very favorable communication, dated June 28th, from Dr. Kenneth M. Lynch, Dean of whom has requested that we contact you, and that you could be of great help to us along this line.

The area covered in this section represents ap-

The area covered in this section represents approximately 1000 families, North, East and South of Varnville and the potential here from a financial standpoint, we believe is a wonderful opportunity for a good Medical Practitioner. This area has the following advantages:

 A very fine Farming section, both grain and truck.

2. Extensive Pulpwood and Pole operations, about the largest in this county.

3. We have three saw mills in the limits of the town with payrolls of more than 250 people, as well as many other rural mills within a 12 mile area.

4. We have a Furniture Square plant here that

employs approximately 50 people.

5. We have a home and office available for a Doctor that is in good shape, if he has a family of four, or we have a splendid boarding accomodation, if single.

6. We have the finest Fishing and Hunting in South Carolina all around this section, with the Salkehatchies River, the Coosawhatchie, the Cumbee, the Edisto and only 35 miles from the finest salt water fishing. This community is wonderful for Deer, Quail, Dove, Fox Hunting, Coon Hunting, Turkey and others that might be interesting to a person that likes outdoor life.

7. We have now approved a fine County Hospital that will be constructed immediately here in Varnville with both white and colored.

8. We have for a small town of 1200 people among the best food, dry goods, general merchandise and meat stores in this section.

chandise and meat stores in this section.

9. We have ample picture shows here and at Hampton, two miles away.

10. We have a Dentist, Three Churches, Methodist, Christian, Baptist, and a few miles away, Presbyterian and Lutheran. Also a Catholic Church at Allendale, 17 miles away.

 We have Drug Stores that can be converted into Prescription Stores almost overnight with the guidance of a Doctor and with past experience of Prescription Drug Store.

perience of Prescription Drug Store. 12. We have a good Fire Department and equip-

ment.

13. We have one of the finest High School systems in this section of the state and have just completed an Athletic High School Field with lights for Football, Soft Ball and other athletic sports. The Baseball Field will not be lighted now. The cost of this is \$10,000,00

14. We have two of the finest Hardware and Furniture Stores in this section of lower S. C.

15. We have, we believe, a most wonderful opportunity for a Medical Doctor or combined Surgeon and Doctor in this area. Definitely, from a financial standpoint there are wonderful possibilities. We have a long standing Veterinarian living here with a very fine reputation, and also a Dentist of long service and reputation in this Town.

We would deeply appreciate anything you may do in assisting us to obtain a desirable man, and would consider it a very great favor, if you would help us in the publications of the S. C. Medical Journal. We feel, through, Dr. Lynch's letter that you can be of great assistance in this matter.

Hoping that you will give this your consideration, and with very kind personal regards and thanks, we

are

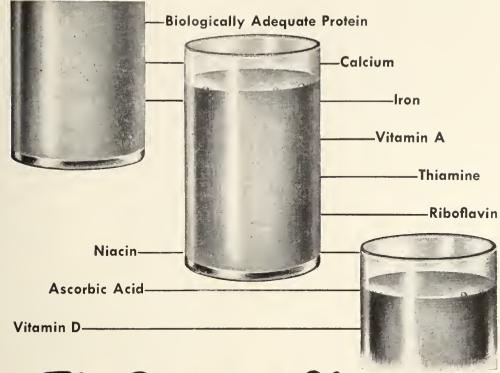
Sincerely yours,
Rev. W. J. Swindell, Prest.
Dr. W. D. Vincent, Dentist
Dr. William Genn, Vetny.
Gulf Rep. W. C. Vann
The Ruritan Committee

Veterans Administration Washington 25, D. C. June 7, 1948

South Carolina Medical Association 105 West Cheves Street Florence, South Carolina

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ity virtually assure patient acceptance, as well as consumption of the recommended three glassfuls daily.

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g.

*Based on overage reported values for milk.

"The Veterans Administration has in its custody the majority of syphilis records of those Army personnel who were treated for this disease while in active service, and in many instances can procure informative data from the syphilis records of other than Army personnel. It is thought that many physicians treating veterans for syphilis as private patients would find a resume of the syphilis record useful since the details of treatment, results of spinal fluid examinations, and blood serologies are incorporated in the records.

Resumes of these records are available to physicians who are treating such veterans provided authorization for the release of the data is given by the veteran. Requests for the resumes accompanied by an authorization for the release of the data, dated and signed by the veteran, should be addressed to the Dermatology and Syphilology Section, Veterans Administration, Munitions Building, Washington 25, D. C. It is most important that the veteran's Service Serial Number and other identifying information, such as the date of enlistment, the date of discharge, rank, and organization be included.

Ordinarily, the resumes can be furnished in approximately two weeks from the date of the receipt of the request and signed authorization".

Sincerely yours, Paul B. Magnuson Chief Medical Director

NEWS ITEMS

Dr. George McFarlane Mood, Jr. has announced the opening of his office for the practice of pediatrics at 275 Calhoun Street, Charleston.

Dr. William J. Nelson is now associated with Dr. James D. Nelson in the practice of internal medicine at 220 Pine Street, Spartanburg.

Dr. Fritz Norton Johnson is now associated with Dr. Frank L. Martin of Mullins.

Dr. Walter Moore Hart (Wally) is now associated with Dr. Julian P. Price of Florence in the practice of pediatrics.

CRIGLER-SMITH

Dr. Hugh Smith, Jr. of Greenville, was married to Miss Mary Susan Crigler of Atlanta on June 2, at Glenn Memorial Church, Atlanta.

JOHNSON-ALLEN

Dr. James Allen of Florence and Miss Lucta Johnson of Marion were married on June 5 at the Marion Baptist Church.

BIRTHS

Dr. and Mrs. W. S. Judy of Greenville have announced the arrival of a son. The baby has been named Murray Stringfellow Judy.

Dr. and Mrs. George R. Dawson of Florence are being congratulated upon the arrival of their third child, a son, born June 1. The baby's name is Alfred Gilchrist Dawson.

Announcement has been received of the birth of a son Philip Whitaker to Dr. and Mrs. E. C. Kinder of Columbia, on June 8th. The following physicians from South Carolina attended the Pediatric Seminar in Saluda, North Carolina, during July:

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Dr. P. A. Brunson	Ridge Spring
Dr. R. J. Davis	Clover
Dr. E. J. Dickert	Newberry
Dr. J. A. Forte	North
Dr. J. B. Galloway	Bishopville
Dr. D. C. Griggs	Pageland
Dr. T. C. Jordan	St. Matthews
Dr. W. H. Mathis	North Augusta
Dr. W. C. Mays	Fair Play
Dr. W. K. McGill	Clover
Dr. C. P. Ryan	Ridgeland
Dr. T. M. Stuckey	Bamberg
Dr. L. D. Wells, Sr.	Holly Hill
Dr. W. C. Whitesides	York
Dr. W. E. Whitley	Andrews
Dr. C. B. Woods	Walterboro

PROGRAM

13th ANNUAL

PIEDMONT POST GRADUATE ASSEMBLY to be held at

ANDERSON MEMORIAL HOSPITAL

Anderson, South Carolina

SEPTEMBER 21 and 22, 1948

Dr. Jack Parker, President

SEPTEMBER 21

3:00 p. m. "Management of Chest Injuries" Dr. Julian Moore, Asheville, N. C.

3:30 p. m. "Panel Discussion Traumatic Surgery"

Dr. Champ Lyons, Ochsner Clinic, New Orleans, La.

Subject will be developed in terms of case reports illustrating the treatment of shock, soft tissue damage, severed tendons, severed nerves, simple and compound fractures.

Dr. A. T. Moore, Columbia, S. C.; Dr. C. O. Bates, Greenville, S. C.; and Dr. Claud W. Perry, Anderson, S. C. will sit on the Panel.

5:00 p. m. "Medical Aspects of Atomic Warfare" Col. Cooney, Surgeon General's Office, Washington, D. C.

6:30 p. m. Banquet-

Speaker—Dr. Douglas Kelly, Bowman-Gray Medical College, Winston-Salem, N. C.

Dr. Kelly is psychiatrist of Bowman Gray Medical College and will discuss some of the problems in psychiatry in terms of the general practitioner.

SEPTEMBER 22

3:00 p.m. "Cancer of Breast"—Ramer Lecture Dr. Elliott Scarborough, Atlanta, Ga.

4:00 p. m. "Some Everyday Problems in Pediatric Practice"

Dr. Julian Price, Florence, S. C.

4:30 p.m. "Obstetrics"

Dr. Nick Carter, Duke University, Durham, N. C. 6:30 p. m. Banquet—

Speakers—Dr. R. B. Durham, Columbia, S. C., Pres. S. C. Medical Assn.; Dr. J. E. Paullin, Atlanta, Ga.

BOOK REVIEW

PRACTICE OF ALLERGY, Second Edition, by Warren T. Vaughan, M. D., revised by J. Harvey Black, M. D., published by the C. V. Mosby Company, St. Louis, Missouri, 1948.

Dr. Black has revised this edition and in doing so has endeavored to continue it as the late "Warren Vaughan's book." He has been assisted by Mr. O. C. Durham, who covers field surveys and aerobiology; Dr. I. B. Howell, who writes on fungus infections with associated allergy; and Dr. James Holman, who has a chapter on vital capacity. After a general discussion of allergy there is a very extensive resume of food and plant allergens in which the basic food product and pollen producers are discussed and many commonly used items listed. Pollens are listed geographically by individual states. Means of diagnosis are thoroughly covered including various methods of testing and the preparation of testing materials. Approximately ninety of the one thousand and seventyfour pages are devoted to a discussion of the allergic diseases (asthma, hay fever, allergie rhinitis, migraine, skin diseases, gastro-intestinal allergy, and cardiovascular disease) largely from a non-allergic standpoint, the remainder of the book being devoted to a coverage of general considerations in the field of allergy. There is a good index which should make the work more useful as a reference volume. Contained in the volume are many excellent photographs and eharts. This work should be of extensive value to the general practitioner, internist, pediatrician, dermatologist, rhinologist and allergist.

W.M.H.

THE SOUTHERN MEDICAL ASSOCIATION MEETING

Miami, Florida, October 25-28

The forty-second annual meeting of the Southern Medical Association will be held at Miami, Florida on October 25-28 with the Dade County Medical Association as sponsor.

At a meeting of the Executive Committee on July 24, Dinner Key was selected as general headquarters for the following: registration; all section meetings, scientific, technical and hobby exhibits; and motion pictures. Dinner Key (the former Pan American Air Depot) is ten minutes' ride from the general hotel headquarters and makes it possible to hold all of the above activities in one location. There is parking space for over a thousand automobiles around the main building.

The evening programs, which will include the General Public Session, the General Session and the President's Ball, will be held at the Municipal Anditorium. The auditorium is just off of Biscayne Boulevard and is only a short distance from the general hotel headquarters.

Hotel reservations will be handled by the Hotel

Committee, Southern Medical Association Meeting, e/o City of Miami Convention Bureau, 320 N. E. Fifth Street, Miami 32, Florida. Since the meeting is being held earlier than usual, all requests for rooms should be made immediately.

There will be twenty-one section meetings, two general sessions, one conjoint meeting (American College of Chest Physicians, Southern Chapter) and the "Miami Day" General Clinical Sessions.

Plans should be made at once to attend the convention. It is hoped that many of the physicians will postpone their vacations for Miami and its environs in October.

WANTED BY THE FBI

Hugo Bob Hubsch, with aliases Robert C. Glass, R. C. Harris, Hogo Hobseh, Louis S. Miller, is being sought by the Federal Bureau of Investigation. On November 7, 1945, a Federal Grand Jury at Jackson, Mississippi, returned an indictment charging this man with a violation of the National Stolen Property Act. He is charged with another violation of the National Stolen Property Act in a complaint filed with a U. S. Commissioner at Birmingham, Alabama, on June 7, 1948. This individual has defrauded numerous physicians and hospitals in Eastern and Southeastern sections of the United States during the past few months through the medium of fraudulent checks.

Investigation has revealed that Hubsch has a chronie kidney ailment and it has recently been ascertained that he has a large kidney stone in the right ureter about four inches below the kidney. This condition has caused local inflammation which, at varying intervals, results in almost unbearable pain. He has been advised that it would be necessary for him to undergo major surgery for the removal of the stone in the near future and until that surgery is performed he will need frequent, if not continuous, medical attention. This fugitive moves about rapidly in that section of the United States which is East of the Mississippi River and recently he has given numerous physicians and hospitals fraudulent cheeks in return for treatment, hospitalization, sedatives and narcotic prescriptions.

The following is a composite description of Hugo Bob Hubsch: Age, about 52, claims to have been born Budapest, Hungary, November 4, 1895; height, about 5'6"; weight, 140 to 170 lbs.; hair, dark brown, graying; eyes, brown; build, medium; race, white; nationality, believed to be naturalized American; occupations, laborer, pharmacist; scars and marks, left arm partially paralyzed, needle scars on both arms, large scars above each hip resulting from kidney operations, shrapnel scars and two bullet scars on abdomen, bridge in upper front teeth; characteristics, long nose, stooped posture.

Anyone having information concerning the whereabouts of this fugitive should immediately notify the nearest office of the Federal Bureau of Investigation or your local law enforcement agency.

South Carolina Medical Association

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The Prevention And The Treatment Of Acute Cholecystitis

George H. Bunch Columbia, S. C.

In this paper we shall show that acute cholecystitis is a more serious disease than has been thought, that in the cases that have been treated conservatively there is a high incidence of gangrene of the gall bladder with perforation and a commensurately high mortality rate, that early operation after dehydration has been overcome and errors in blood chemistry have been corrected gives the patient a better chance of survival, that the majority of the cases of acute cholecystitis may be prevented by the prompt removal of all gall bladders containing stones and, finally, we shall discuss the surgical management of the acutely diseased gall bladder.

Heuer³ in 1937 collected from the literature 500 cases of acute cholecystitis that had been treated medically. In 20% of these gangrene and perforation had occurred with 45.5% mortality. Cowley and Harkins2 in 1943, in a review of the literature for 1924 to 1942. found 2261 cases of acute cholecystitis of which 13% had perforated with a mortality rate of 20.8%. Glcnn6 in 1947 reported that in the New York Hospital over a period of 16 years, from September 1, 1932 to September 1, 1946, 555 cases of acute cholecystitis were operated upon. In the 187 patients over 50 years of age the mortality rate was 6.1%, in those under 50 years, 1.08%. He says, "In those patients over 50 years the temperature, the leucocyte count and even the clinical picture frequently do not parallel the pathological process which is taking place within the gall bladder. It is in this group particularly that we feel early surgery is imperative.'

Johnstone and Ostendorph, in a series of 12,000 consecutive autopsies done at the Los Angeles County

Hospital from April, 1936 to January, 1942, found 32 cases of perforation of the gall bladder, an incidence of 0.26%. Of these 43% had free perforation without walling off. In 4 cases there was perforation into the ducdenum and in 1 of these there was also a perforation into the jejunum. In 84% of the cases with perforation stones were found in the gall bladder or ducts, showing the great frequency with which acute cholcevstitis and perforation occur in long standing chronic biliary disease. Forty-nine per cent of the cases treated medically died of perforation and peritonitis unrecognized and undiagnosed until at autopsy. They also report from 2 hospitals in Los Angeles a series of 105 cases of acute cholecystitis in which cholecystectomy was done in 86 and cholecystostomy in 18 with an overall mortality rate of 8.5%, showing, contrary to the usually accepted belief, that acute cholecystitis ranks high among the acute abdominal diseases as a cause of death.

Such statistical studies definitely prove that complacent waiting in acute gall bladder disease until the cooling off period has passed when an interval operation may be done with comparative safety is a fallacy with no more factual basis than there is in delaying operation in acute appendicitis. As the public and the medical profession have learned the danger of procrastination, of catharsis and of delayed operation in appendicitis the percentage of late cases with perforation already present when first seen by the surgeon has steadily declined with a corresponding fall in the death rate. In an earlier series of appendicitis cases operated upon by us 20% had already perforated. At the present time, 12% have perforations at operation.

The etiology of acute cholecystitis has an important bearing on its prevention. The duodenium, the pancreas, the liver and the biliary system are embryologically derived from the same segment of primitive

Read before the South Carolina Medical Society, Charleston, S. C., April 27, 1948.

gut and throughout life are related in function and in predisposition to disease. An influx of panereatic juice into the gall bladder results in acute cholecystitis and, conversely, pancreatitis follows the escape of infected bile into the pancreatic duct. Chronic pancreatitis is a common complication of chronic gall bladder disease and there is an increased incidence of gall stones in diabetes.

Stones are found only in diseased gall bladders and, stones even though silent and symptomless, are not harmless. Even when not obstructive, they in time result in progressive degenerative changes in the liver, the pancreas and the kidneys that shorten the life of the patient. In 72+% of our cases acute cholecystitis has occurred as a complication of chronic cholecystitis with stone. When this develops there is increased hazard of perforation, peritonitis and death.

Furthermore, 90% of the gall bladders developing cancer have stones which is perhaps the best example in the human of chronic irritation eausing malignancy. Samburg and Garlock, 16 February, 1948, report having operated upon 65 out of a series of 75 cases of carcinoma of the gall bladder with only 1 survival at the end of 3 years. They conclude, "This in addition to other frequently fatal complications of chole-lithiasis, constitutes an obligation to remove all calculus gall bladders, in the absence of surgical contra indications." The internist who persists in treating a patient with gall stones by any sort of dietetic or conservative regime assumes an unwarrented responsibility.

We have yet to see a case of chronic eholecystitis in which the disease has been initiated by an attack of acute cholecystitis of sufficient severity to be recognized clinically but, paradoxically, the majority of the cases of acute cholecystitis, in our experience, occur as complications of chronic gall bladder disease and lithiasis of long duration.

Whipple 4 says, "In the pathogensis of every lesion of the gall bladder and bile duets requiring surgical therapy 3 factors will be found, singly or in combination:

- A disturbance in the normal metabolism of the ingredients of bile, especially in the bile salts-cholesterol ratio resulting in inflammation or gall stone formation or both.
 - 2. Infection by baeteria.
 - 3. Obstruction with bile stasis."

Even in cases of acute cholecystitis in which infection is not the primary factor it supervenes and plays an important secondary role. Rosenow has stressed the frequency of infection by streptococci. One of our cases of acute cholecystitis without stones followed a furnicle on the hand.

The role of the typhoid bacillus in gall bladder disease has been important. In typhoid carriers the organism remains indefinitely in the gall bladder and stones have been found to harbor typhoid bacilli in their centers for many years. In an earlier review of cases we reported having drained with recovery an empyema of the gall bladder in a white girl 9 years old ill with typhoid fever. Of 30 cases reported by Keen⁵ in 1898 of perforation of the gall bladder in acute typhoid cholecystitis 3 recovered and 27 died. All those that recovered were operated upon. The undeveloped state of gall bladder surgery then is shown by his description of the operative technique employed. "If the walls of the gall bladder in the ueighborhood allow it, one or two rows of Lembert sutures, inverting the peritoneal coat is the method of repairing the perforation, should this not be possible, then the best plan would be circular packing around the opening with iodeform gauze, so as to form a defensive wall for the abdominal viscera, leaving in the center a sort of well leading down to the perforation. This should be separately packed. The incision should never be entirely closed, drainage being essential."

We now know typhoid to be a preventable disease that is disappearing from civilized countries. Would that the role of the colon bacillus in biliary infection might be as effectively eradicated. Dehydration and urinary stasis have long been recognized as factors in the formation of urinary stones but the causative effect of bile stasis in the development of gall stones is not yet appreciated. We are convinced that concentration from dehydration and stasis changes the composition of bile, predisposes to infection and results in stone formation. In our work it has several times been the cause directly or indirectly of acute cholcevstitis developing in patients already having chronic gall bladder disease. Many years ago we removed an acutely diseased non calculus gall bladder from a man who had been immobilized four weeks in a body cast for fractures of both femurs. We worked through a window in the cast. There was no history of previous gall bladder disease. He recovered. We have also operated for acute cholecystitis upon two fat women of middle age who had been confined to bed with Buck's extention applied for leg fractures. Both gall bladders contained stones. Unless such patients are kept hydrated and made to exercise in bed there is bile stasis, particularly in the aged. Glenn,6 at the 1947 meeting of the American Surgical Association, reported a series of 17 cases that developed acute cholecystitis following surgical procedures unrelated to the biliary traet. We believe bile stasis from loss of muscle tone and lack of exercise plays an essential part in the relative frequency of gall bladder disease in women as compared to men, in fat women as compared to thin women and in white women as compared to negro women.

The first surgical operation upon the gall bladder, cholecystotomy, was performed by Marion Sims 5 for acute cholecystitis in 1878. Because it gives better relaxation and is safer we prefer spinal anaesthesia in gall bladder surgery and ordinarily use, except in

cases that are not jaundiced, the transverse incision. With it closure is without tension and the wound heals at rest. There are less respiratory embarrassment and fewer chest complications; breathing is deeper. pain is less. In many patients, because of edema and induration, the ducts in acute inflammatory disease of the gall bladder are not readily identified and may be satisfactorily visualized only at a considerably increased hazard. In such patients, in the absence of jaundice or of a palpable stone, we think it unwise to explore the common duct, Gangrene of the gall bladder from thrombosis of the cystie artery is not rare. If there is also necrosis of the cystic duet it may be impossible to ligate either the duct or the artery particularly in obese patients. In no case in which this has occurred has there been secondary hemorrhage and in the absence of obstruction of the common duct healing has been without bile drainage.

The patient with acute eholecystitis is acutely ill and should be operated upon early but not until dehydration has been overcome and electrolytic balance restored. The great majority of these patients are in the middle and in the old age groups. At operation the primary indication is to save life by adequate drainage of the septic gall bladder. Only if the patient's condition permits should its radieal removal be attempted. In patients operated upon within 48 hours of onset the gall bladder may often be totally removed without undue trauma and without bleeding. In suitable cases it may readily be separated from the liver along a relatively avascular line of cleavage. As a rule, however, particularly in late eases of acute cholecystitis total removal of the gall bladder is difficult and hazardous. It is now known that after simple drainage the gall bladder wall remains infected and that 50% of the patients having eholecystostomy, in order to be cured, must have subsequent cholecystectomy. Cholecystostomy is in effect a palliative, not a curative procedure. Because of these facts several methods of performing subtotal cholecystectomy have been suggested. These have the curative effect of total removal without its hazards. Such procedures must be accomplished with minimal dissection and without shock.

Martin 14 in 1920 and again in 1926, in 7 cases of empyona of the gall bladder in which elassical cholecystectomy might not be safely done, reported having split the gall bladder from end to end and applied tincture of iodine to destroy the mucosa.

Gatch 7 in 1930, after walling off the gall bladder with moist pads and aspirating its fluid contents, opened the fundus, removed any stones that were present, split the gall bladder from fundus to ampulla, destroyed the nucosa by the application of moist swabs wrung dry after having been dipped in pure carbolic acid (or by the actual cautery), and sutured with fine catgut the walls of the gall bladder after they had been folded around a soft rubber catheter which had been placed for drainage to or perhaps

for a short distance into the end of the cystic duct.

Heyd³ in 1935, by a similar technique, split the gall bladder and removed the mucosa by stripping. Thorek³ in 1935 advocated in all cholccysteetomies, acute and chronic, electro coagulation of the wall after the gall bladder had been opened its entire length. Closure was without drainage. Bailey and Love¹² in 1939 report having done 129 eases by the Thorek method with no deaths. Pribram¹⁰ in 1928 practiced mucoclasis instead of cholccysteetomy. After aspiration he destroyed the gall bladder mucosa by means of an electrode placed in the lumen. Wound closure was without drainage. Whitaker¹¹ in 1935, used the high frequency current to destroy the mucosa in a procedure he called electro surgical cholccystectomy.

Carpenter and Vale¹³ in 1942 reported 47 cases of acute eholecystitis operated upon, by the Gatch method of using earbolic acid for the destruction of the gall bladder mucosa, with a mortality of 8%. Of the 34 patients contacted 18 had Graham Cole examinations from 6 months to 4 years after operation. Of the 18 seven were visualized in varying concentrations of the dye (39%). Some of the gall bladders which did not function before operation were now visualized. In 6 to 9 months the mucus membranes of experimental dogs operated upon by this method appeared normal except for fibrosis.

In our work we have modified the Gatch method of using carbolic acid in chemical eholeeysteetomy in 2 essential ways: 1st-after splitting the gaugrenous gall bladder from fundus to ampulla we remove all the wall except the narrow strip that is attached to the under surface of the right lobe of the liver; 2ndthe mucous membrane of this may be stripped off or it may be destroyed by leaving in contact with it a strip of gauze wrung dry after having been dipped in carbolic acid. The gauze, with a protecting rubber dam, forms a cigarette drain which is removed on the 6th post operative day. We believe prolonged contact of the acid with the mucosa destroys all surface and glandular epithelium. Leaving only the portion of wall that is attached to the liver makes reformation of the gall bladder mechanically impossible. To prevent necrosis and stricture of the bile ducts there should be no excess acid to gravitate downward and pool about them. We have found this procedure to be a relatively safe, satisfactory way to treat acritely diseased gall bladders. It combines the benefits of cholecystectomy with the safety of cholecystostomy. Of the patients operated upon all have done well post operatively and those having gangrenous gall bladders done in this way but without the use of the acid have also done well. We wonder what the effect would be if the posterior wall of an untreated normal gall bladder were left attached to the liver. The gall bladder secretes mucons which, if not absorbed by the peritoneum until the glands secreting it had atrophied, would form an intraperitoneal cyst.

Of the 61 patients having aente cholceystitis

operated upon by us in the decade from January 1, 1938 to January 1, 1948 all were white, showing the rarity of gall bladder disease in the negro race; 13 were males, 48 females, a proportion of about 1 man to 4 women. Stones were found in the gall bladder or ducts in 44 and not found in 17, a relative incidence of more than 21/2 to 1, showing the importance of the removal of gall bladders with stones in the prevention of acute cholecystitis. Of the 60 cases 2 were between the ages of 20 and 30, 7 between 30 and 40, 7 between 40 and 50, 22 between 50 and 60, 13 between 60 and 70, 4 were over 70, in 4 the age was not given. The youngest patient was 21, the oldest 77, almost 70% have been 50 or older. There has been no case in which cholecystostomy was done. The carbolic acid technique of subtotal chemical cholecystectomy that we have described was used in 12 patients and the posterior wall of the gangrenous gall bladder was left without the application of carbolie acid in 4, all 16 recovered. Classical cholecystectomy was done in the remaining 45 cases with 6 deaths, a mortality rate of 13-1/3%.

All deaths have been in patients approximately 50 years of age or older:

- 1. A woman, 48 died on the 16th post operative day of septicemia from a complicating abortion. This was before the days of penicillin and streptomycin.
- 2. A mentally deranged man, 59, after having had a boil on his hand for a week, developed acute cholecystitis. At operation no stones were found. On the 7th post operative day he suddenly died of pulmonary embolism.
- 3. A woman, 50 was admitted with temperature 105°, leucocytes 11,500, polys 87%. She had empyema of the gall bladder with stones. She died on the 2nd post operative day of anuria and toxemia.
- 4. A woman, 67, with subnormal temperature, 4500 leucocytes, 84% polys was admitted at 11 P. M. after having been taken acutely ill the same morning while riding in an automobile to the mountains. She was brought by ambulance to Columbia from a hospital in Spartanburg. On admission here she was acutely distended and had vomited repeatedly during the day. Her pulse was hardly perceptible. She was given glucose intravenously and continuous stomach suction through a nasal tube. Next morning, although she was in extremis, the gangrenous ruptured gall bladder containing stones was removed. Several quarts of bile were found in the free peritoneal cavity. She died in a few hours.
- 5. A woman, 50, was admitted with temperature 104° , 11,800 leucocytes, 83% polys. At operation she had a ruptured gall bladder with stones. She had extensive careinoma of the gall bladder with secondary masses in her liver and died on the 2nd post operative day with temperature 108° , a liver death.
 - 6. A woman, 61, with paraplegia following an

apoplectic stroke 5 months previously was admitted with temperature 103°, 16,300 leucocytes and 85% polys. She did well for several days after the removal of an acutely infected gall bladder with stones, then the right leg became gangrenous, probably from circulatory block by an embolus, and she dicd after amputation of the thigh.

Several of the cases that have recovered deserve brief mention; one a woman who had acute cholecystitis apparently precipitated by hemorrhage into the gall bladder from erosion by stones into a branch of the eystic artery. Another woman at cholecystectomy was found to have a complicating pseudo myxoma peritonei from a ruptured mucocele of the appendix. Two cases have had subsequent laparotomies. A woman became mildly faundiced 6 months after the removal of a gangrenous ruptured gall bladder without stones. At the 2nd operation a non-faceted stone was removed from the common duct. Was the stone, overlooked at the 1st operation, a predisposing cause of the acute attack or had it developed in the common duct afterwards? She has done well since operation and has been relieved of jaundice. A woman. 69, had vaginal hysterectomy and perineal repair done June 28, 1947 for torn perineum, massive cysticele and rectocele. On July 15, 1947, while still in the hospital, she beeame acutely ill and was operated upon for a gangrenous ruptured gall bladder with stones after which she did well and was dismissed on August 4th, 1947. On December 3rd, 1947 she was readmitted with fever, and tenderness over the epigastrium. X-ray examination showed a right subphrenic abscess. This was drained, since which time she has remained well. In her, from bile stasis 20 days after hysterectomy, acute cholecystitis developed in a ehronically diseased calculus gall bladder. Penicillin in massive doses did not control the infection. Hers is the only case in our experience that has had subphrenic abscess as a post operative eomplication of gall bladder surgery.

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Plate No. 1—Dec. 29, 1947 shows right subphrenic abscess.

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Plate No. 2—Jan. 6, 1948 shows that abscess has been adequately drained and that right lung is expanding.

A Clinical Consideration Of The Erythrocytic Sedimentation Rate

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In any consideration of the sedimentation rate there are certain basic factors which should be recalled so that we shall have a clearer conception of physics and physiology as they are related to this test. Therefore, it may be worthwhile to refresh our minds with some of these facts. A cubic centimeter of packed red cells weighs about 1.09 grams and a similar volume of plasma weighs 1.06 grams. It is understandable that the red cells sink in the plasma. The rate of fall will depend upon the difference in weight of cells and resistance of upward pressure of plasma and it will become constant when these forces are equal to each other. The smaller the aggregate, the lesser the diameter, the lighter the weight, the slower the fall; for the resistance is proportional to its diameter, but its weight is proportional to the cube of its diameter. Therefore, discrete cells fall slower than their agglomoration, but amount of viseosity of plasma and other particles in the blood affect their rate of fall. Abnormal states in the plasma which interfere with its normal function of cell separation would cause rouleaux formation. This abnormal physical state of the plasma may be brought about by increasing the fibringen and globulin or by decreasing the albumin. Apparently certain fractions of protein maintain cell separation while others lead to rouleaux formation and thereby increase the sedimentation rate. However, there may be other factors connected or associated with the accelerated fall of red cells which do not lend themselves to our present day knowledge. But any destruction of tissue, infection or allergic state that alters the plasma proteins by increasing the fibrinogen and euglobulin usually will increase rouleaux formation. This abnormal physical state is the most logical explanation for the accelerated fall of these eells.

According to Fahrens, tissue destruction causes an accumulation of albuminous products in the plasma which upsets the suspension and electrolytic stability. Also, he believes that other factors such as specific gravity and viscosity of the plasma, shape and size, separation or agglomeration of red cells must be considered before an evaluation of this procedure can be of clinical significance.

The erythrocytic sedimentation test is of diagnostic value only when it completes a definite pattern of some organic disease. The test is non-specific and

when considered alone is often misleading. It is a laboratory procedure and when used in conjunction with history, physical findings and clinical observation may be of diagnostic aid, Apparently there is some coordination between erythrocytic sedimentation rate and cellular destruction. It is their interpolation into the terms of physiology or pathology of the clinical case which may be pertinent in arriving at a correct diagnosis. With a good history and meticulous examination, clinicians make correct diagnoses in most instances. But in some of their cases a degree of doubt exists and for this reason there is a desire for quantative information which can be assessed in solving this problem. But these figures may be even more misleading unless the clinical evaluation is considered in the same category as other information relating to the patient. The sedimentation test, like most other laboratory procedures, is not specific of any clinical entity. But when considered as a unit of the necessary tests to be used in a given case it can be very helpful in arriving at a correct diagnosis and may be of equal value from a prognostic standpoint,

Since this knowledge has somewhat crystallized sufficiently to be of diagnostic aid many outstanding laboratory workers have formulated methods for executing the erythrocytic sedimentation rate. They are similar in principle, but different in some of their details. Therefore, the normal values will vary according to the method employed, which should always be designated by the laboratory. The rate of fall is generally expressed in terms of millimeters per hour. The methods of Westergren, Wintrobe and Cutler are in common use and each has formulated what be considers normal for men, women and children.

	Men	Women	Children
Westergren	0-15 mm.	$0-20~\mathrm{mm}$.	Less than 10 mm.
Wintrobe	0-6.5 mm.	0-15 mm.	3-13 mm,
Cutler	0-8 mm.	0-10 mm.	

The specific techniques for these procedures are obtainable in any standard laboratory manual. It is simple in manner and can be executed by the average office personnel.

We have attempted to discuss some of the physics, physiology and pathology in connection with the erythrocytic sedimentation rate and now believe that it may be worthwhile to try to correlate the application of the test with the elinical findings so that this proeedure may be helpful in solving some of our diagnostic and prognostic problems.

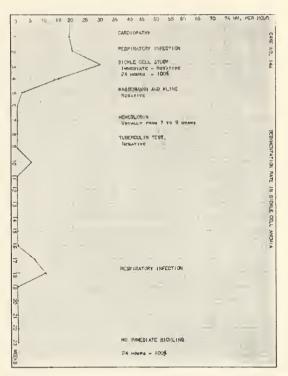
In most of the acute infections the sedimentation rate will be elevated, but will return to the normal range with recovery of the patient. Sometimes when the general examination does not indicate the presence of disease, an abnormal fall of the erythrocytic eells may be the stimulus for a more concerted examination and follow-up of the patient so that we may determine the exact cause of this increased sedimentation rate.

From a pediatrie standpoint, we believe that the erythroeytic sedimentation test is more commonly used and is of greater clinical value in rheumatic fever, nephritis, tuberculosis and siekle cell anemia than in most of the other childhood diseases which one may contact in his practice. Therefore, it may be worthwhile to discuss some of these conditions a little more in detail.

Beeause of the high rate of occurrence of sickle cell disease in the colored race and because of the varied clinical picture which may somewhat simulate rheumatie fever, we should remember that this disease does produce myoeardial pathology and that this development may change the normal physiological pattern and present a elinical picture not unlike that of rheumatic fever. This particular pattern may present a problem in differential diagnosis which may be difficult to solve unless we remember: (1) that the sickle eell phenomenon occurs only in the negro race: (2) that without complications it does not increase the sedimentation rate, but eauses a slow fall; (3) that there is a more marked tendency of these patients to develop a severe degree of anemia and jaundiee; (4) that in most instances sickling of the red cells can be demonstrated; (5) that there is a reticulocytosis and often demonstrable x-ray changes in the bones suggestive of this disease; (6) that there is a lack of response of these patients to salieylate therapy. Therefore, the erythrocytic sedimentation rate is very helpful in differentiating rheumatic earditis from cardiopathy of sickle cell disease.

It may be worthwhile to present a typical graph of sickle cell anemia, so that we may have a clearer conception of this laboratory procedure as a part of the clinical pattern of this disease.

The erythroeytic sedimentation rate may be of some value in following the elinical progress of children who have the primary type of tuberculosis. Many of these cases develop some of the early manifestations which are not unlike those seen in rheumatic fever. They are peevish, run a low grade fever, develop anemia, often complain of vague pains in the legs and of tiring easily. Frequently there is heard a soft, blowing systolic murmur. The weight graph may be downward, stationary or retarded. The intradermal tuberculin test may be one plus or more. The x-ray may or may not reveal any evidence of tuberculosis. In these types of

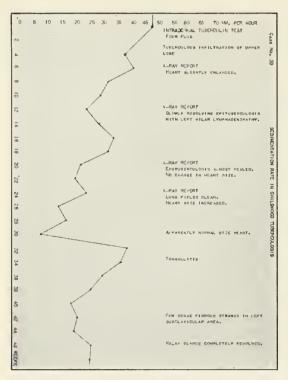


Case No. 145

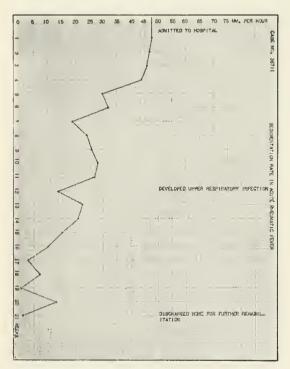
cases it is often difficult to tell whether we are dealing with an atypical type of rheumatic fever or an early type of primary tuberculosis. In this stage, both of these diseases may present an elevated sedimentation rate and without further observation and more definite patterns of these entities it may be extremely difficult to evaluate and correctly place this laboratory procedure. However, the sedimentation rate is of more definite value in determining the activity of the tuberculous infection and is often elevated even though there is x-ray evidence of healed lesions. We are presenting a graph somewhat suggestive of this type of ease.

In rheumatic fever the erythrocytic sedimentation rate is elevated and it gradually returns to normal over a period of weeks or even months as the active process subsides. In 140 patients under observation in our Rheumatic Fever Clinic and considered to be in the acute phase of this disease, the average sedimentation rate was 20.8 mm. hr. One-hundred-and-forty-six patients in whom the rheumatic process had become quiescent showed an average rate of 7.6 mm hr. The following graph is illustrative of the usual course of this disease.

Its great value lies in the fact that it may indicate continued activity when other clinical evidence is no longer present. A sedimentation rate that has returned to normal and remained within the normal limits for three to four weeks after salicylate therapy has been discontinued is generally accepted as a reliable indication that the rheumatic process is quiescent and that



Case No. 39

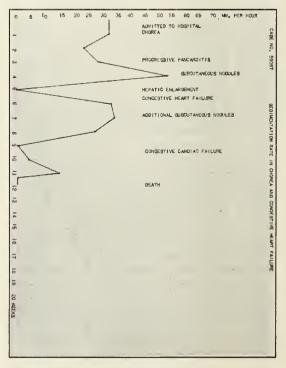


Case No. 36711.

graduated activity may be permitted. However, in the application of the sedimentation rate to determine the duration of bed rest following the acute stage, it is necessary to exclude other infections. From an economic and psychologic standpoint an unnecessarily prolonged period of bed rest is undesirable.

The erythrocytic sedimentation rate may be of aid in the evaluation of vague muscle and joint pains, commonly called "growing pains," or other equivocal symptoms of rheumatic fever in children. Systolic murmurs are frequently heard in the routine examination of children who are apparently well. Such murmurs may not be significant, but they deserve further consideration. In these cases an elevated sedimentation rate for which no other explanation is apparent suggests the possibility of rheumatic fever and indicates that the patient should have continued observation and examinations.

In severe cases of rheumatic fever, it has been observed that with the onset of congestive heart failure the previously elevated sedimentation rate tends to decrease to levels which would, in other circumstances, be considered normal. This decrease in sedimentation rate may precede obvious signs of failure and serve to warn the clinician of an impending cardiac break. If the heart failure is overcome, the sedimentation rate again rises to its former elevated level. This course of events is illustrated in the following graph which shows successive sedimentation rates in the case of a five year old colored female who was admitted to the hospital with chorea associated with a progressive pan-carditis, the development of subcutaneous nodules, and eventually the development of congestive heart failure and death. This case also



Case No. 59067

illustrates the fact that the majority of our patients with chorea have had an associated cardiac involvement and an elevated sedimentation rate.

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Operative Treatment of Intestinal Obstruction

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Intestinal obstruction can be treated effectively by operative means and without the aid of long tube decompression. The use of the Miller-Abbott tube and its modifications has contributed much to the treatment of intestinal obstruction. However, numerous technical difficulties have been encountered in the use of these long tubes. During the residency period of one of us so much time was spent in the manipulation of Miller-Abbott tubes, that all the surgical residents were barred from the fluoroscopic rooms because they were receiving excessive radiation.

The results of operative treatment with modern supportive care of intestinal obstruction but without the aid of the Miller-Abbott tube should be reviewed.

Source: In this hospital the radiologist was already receiving maximum exposure to radiation and could not take part in fluoroscopic manipulation. Especially because of technical difficulties without the aid of fluoroscopy, long tube decompression was not used in this series. The group used for this report includes all of our cases from July, 1945 until September, 1947 and are consecutive private cases in a general hospital and should be representative.

There were twenty-seven cases of acute intestinal obstruction during this period. Chart I gives a short case summary of the twenty-seven cases.

Discussion: Would long tube decompression have reduced the mortality in this group? The single death occurred as a result of the extension of a small area of thrombosis in the mesentery of the intestine. This was a case of advanced volvulus. After reducing the torsion, the blood supply of the intestine returned nicely, and the wall had good color. Because of adequate blood supply, it was thought that resection was not necessary. There was an area of thrombosis in the mesentery about 4 cm. in diameter. The involved bowel was short-circuited by a side to side anastomosis because of the possibility of stricture formation at one of the two areas of constriction. The post-operative course was satisfactory for four days. Then the patient went into shock, and the abdomen became distended and rigid. At operation it was found that the small area of thrombosis in the mesentery had extended to the superior mesenteric artery. The patient became moribund and was closed without any operative procedure and died two hours later in spite of intensive supportive therapy.

There are two factors which might have prevented extension of the thrombosis. Earlier operation may have reduced the chance of thrombus formation. Rescetion of the area of thrombosis in the mesentery with the involved intestine may have prevented spread. It is felt, however, that long tube decompression would not have prevented the mortality. It might have delayed operation even further and would not have affected the situation as far as the possibility of resection was concerned.

PRINCIPLES OF OPERATIVE TREATMENT

Recently much stress has been placed on the proper use of long tube decompression, but the principles of operative treatment have not received much attention. They will be reviewed at this time. *Pre-Operative*:

- (1) The level of the obstruction is ascertained as nearly as possible by careful history and physical examination and by x-ray findings.
- (2) The abnormal metabolic state of the patient is corrected as much as can be done in the time that the situation permits. Large amounts of plasma are usually necessary. Total and fractional serum proteins and hematocrit studies may be of value, but the amount used is that necessary to give an adequate circulating blood volume. Dehydration is corrected and electrolyte loss replaced.
- (3) A Levin tube is placed in the stomach and suction instituted, completely emptying the stomach before operation.

At Operation:

- (1) The tube is left in place and suction applied intermittently during the operation. This prevents regurgitation of intestinal contents into the pharynx of the patient with possible subsequent aspiration.
- (2) Spinal anesthesia has many advantages and has been used in all of our cases. Adequate relaxation is necessary and is hard to obtain with general anesthesia. General anesthesia combined with curare is an alternative.
 - (3) An adequate incision for exploration is made.
- (4) After the abdomen is opened, the distended loops of bowel are avoided as much as possible and are not handled. Instead, the cecum is first located. If it is not distended, the terminal ileum is traced in a retrograde manner. This will be found to be empty and flat in cases of obstruction of the small intestine. This flat bowel is traced backward to the point of obstruction, handling the distended bowel as little as possible. It is sometimes necessary, however, when the bowel proximal to the obstruction is quite dilated,

to deliver it out of the peritoneal cavity before the point of obstruction can be visualized. The exposed dilated bowel is covered with warm saline compresses.

- (5) The flat bowel is traced up to the point of obstruction, and the obstruction is released. If it is due to a band adhesion, this may be very simply the release of the band. Frequently a considerable portion, or several portions of the small intestine may be found to be adherent for a wide area with a volvulus in between. The obstruction is released, doing whatever is necessary, and the intestine delivered through the incision. At this point, considerable intestinal content usually passes the point of obstruction, and the flat bowel begins to fill.
- (6) All areas are carefully peritonealized at the point where the intestine was adherent. In short areas this can be done by a transverse suture, bringing the serosal edges together. In some instances, plication of the intestine is of some value. By this procedure the intestine is folded, bringing adjacent portions of intestine side by side and suturing them there by easy loops, making the folds so that there are no sharp angulations. Extensive raw surfaces may be covered by this procedure of plication. In other instances, the portion of intestine with an extensive raw surface may be wrapped in omentum and left with the omentum to become adherent to the raw surface.
- (7) In any case of obstruction, after the obstruction has been released, the intestine is held up and the mesentery inspected down to its root. If this is not done, a twist of the mesentery may be overlooked. If a volvulus is present, the condition is corrected, using whatever procedure or maneuver is necessary.
- (8) If the closure presents considerable problem because of marked distention, it is advisable at this point to decompress the intestine. This may be done in the following manner: A short McBurney incision is made and the appendix delivered. The peritoneum is closed around the base of the appendix and this incision is closed, leaving the tip of the appendix protruding. One member of the operative team isolates himself in a small area away form the main operative field. The tip of the appendix is clipped off and a catheter inserted into the cecum. If necessary, this catheter may be threaded up into the ileum by one of the other members of the operating team working from within the abdomen. A long section of the intestine can be threaded on the catheter, with decompression by suction applied intermittently as the catheter is threaded on. By this maneuver the amount of distention can be greatly reduced and the incision closed with ease.

In cases where the appendix has already been removed, or in cases where it is not readily delivered or seems too small, the most accessible portion of the ceeum is sutured to the peritoneum through the Mc-Burney incision, thus isolating that portion of the ceeum from the general peritoneal cavity. The main

field is protected from contamination, and the cecum is opened after placing a purse-string suture and a large rubber tube inserted in the cecum. If additional decompression is necessary, this tube may be threaded into the ileum, and again the maneuver of threading the intestinc on the tube can be done. In either case, the tip of the tube is left in the cecum and serves as a valuable aid in decompressing the patient post-operatively.

After all distention has subsided, the bowels are moving normally, and the condition of the patient is good, the tube may be removed. If cecostomy without appendicostomy has been used, the tube is removed when the suture holding the tube in place has been absorbed.

If one is ready to remove the tube, but the suture is still holding it, traction with a rubber band is applied to the tube so that the suture gradually sloughs through the wall of the intestine or the peritoneum to which it has been sutured. Traction may be replaced or adjusted when necessary. The traction is applied by fastening the rubber band to the skin with adhesive.

In cases where an appendicostomy has been used, preserving the appendix, the appendix is pulled up with the tube still in place, and by blunt dissection and traction the base of the appendix is expessed. A tie is placed there and the tube slipped out. The appendix is tied off with two chronic ligatures and amputated. A drain is left to the appendix stump. The peritoneal cavity is not opened during this procedure. Although a fecal fistula may develop, it has not done so in any of our cases and should not prove troublesome or last very long if it should develop.

(9) The principles of operative treatment of the usual obstructions of the colon, cecum, and rectum will not be discussed at this time. In the preceding section it was noted that the cecum is picked up first. If it is found to be distended, an unexpected obstruction of the colon is probably present. The remainder of the colon is rapidly examined to determine the level of the obstruction and to rule out volvulus. In this type of case it is usually advisable to decompress by eccostomy or appendicostomy and leave definitive measures or complete diversion of the fecal stream until later.

Discussion: The principle of careful peritonealization to reduce the number of adhesions and to avoid future obstruction should be emphasized. This principle is important in any phase of abdominal surgery. All abdominal operations in a one year period (1946) were reviewed. In 220 consecutive abdominal operations, giving attention to avoiding raw surfaces, one case of post-operative obstruction has occurred up to the present time and is included in the previous discussion. The obstruction incidence was 0.4 per cent. It is unlikely that any cases of obstruction were over-

14.00 1.00	Number	Age Sex	Diagnosis	Associated Conditions	Operation	Result
127,256	117,682			None		Recovered
19,349 Sweeks Imperforate A nu s, with shall be not al, incare and the control of the shall be not al, incare and the control of the shall be not al, incare and the control of the shall be not al, incare and the control of the shall be not al, incare and the control of the shall be not al, incare and the control of the shall be not al, incare and the control of the shall be not al, incare and the control of the shall be not al, incare and the control of the shall be not all the sha	127,256	58	Spontaneous perforation of		Colostomy.	Recovered
Sweeks Imperforate A n u.s. with mail fixed mail			plete obstruction of recto-		vie abseess.	•
128,713 35 Inguinal heraia, incarcerated seguinal heraia, incarcerated seguinal heraia, with strangulation of Beam. Heraiorrhaphy. H	129,349		Imperforate Anus, with	None	Anastomosis, rectum to skin.	
128.143 1 Year mearcerated inguinal hereins Some Reduction of ilcum. Recovered Reduction of ilcum. Recovered Recovered Reduction of ilcum. Recovered Reduction of intussusception. Recovered Recovered Reduction of intussusception. Recovered R	129,701	35	Inguinal hernia, incar-	None	tion of strangulated omen-	
133,416 Seconds Intussusception. None Reduction of intussusception. Recovered	128,143			None	Reduction of ileum.	Recovered
134,385 Newborn Intussusception. None Reduction of imperforate anus. Recovered	133,416	6 months		None		Recovered
Intussusception None Reduction of intussusception Recovered	134,388	Newborn	Imperforate Anus.	None	Repair of imperforate anus.	
Second S	130,507	7 months	Intussusception.	None	Reduction of intussusception.	
104,517 48 Complete obstruction of sign Male workiedulum Complete obstruction of sign Complete obstruction of sign Complete obstruction of sign Complete obstruction of strangulated lines Complete obstruction Complet	68,049	38	tion due to post-operative ad-	None	Release of adhesions.	Recovered
Semale With intestinal adhesions, Mose Mose	104,057		Complete obstruction of sig- moid due to ruptured di-			Recovered
136,01 30 Ruptured diverticulum of Male colon with absess formation and complete obstruction of signal colon with absess formation and complete obstruction of signal colon with absess formation and complete obstruction of signal colon with absess formation and complete obstruction of signal colon with absess formation and complete obstruction of signal colon with absess formation and complete obstruction. None None Reduction of lieum. Recovered	10,547		with intestinal adhesions. Mcsenterie thrombosis, mas-	None	sions and volvulus and in- testinal anastomosis.	Died (Sec discus sion in text.)
132,079 72 months Intussusception. Male 138,992 50 Incarcerated hernia with ale Strangulated lieum. None Reduction of ileum. Recovered Recovered Reduction of ileum. Recovered Reduction of ileum. Recovered Reduction of ileum. Recovered Reduction of ileum. Recovered Recovered Reduction of ileum. Recovered Recov	136,011		Ruptured diverticulum of colon with absecss formation and complete obstruction of	None	Wangensteen suction and antibiotics. Sigmoidoscopy.	Recovered
138,992 50	132,079			None		Recovered
112,679 Newborn Atresia of rectum. None Anastomosis of sigmoid to gluteal skin. Plastic construction of anal canal. Release of adhesions. Recovered to gluteal skin. Plastic construction of anal canal. Release of adhesions. Recovered to gluteal skin. Plastic construction of anal canal. Release of adhesions. Recovered to gluteal skin. Plastic construction of anal canal. Release of adhesions. Recovered to gluteal skin. Plastic construction of anal canal. Release of adhesions. Recovered to gluteal skin. Plastic construction of anal canal. Release of adhesions. Recovered to gluteal skin. Plastic construction of anal canal. Release of adhesions. Recovered to gluteal skin. Plastic construction of anal canal. Release of adhesions. Recovered to gluteal skin. Plastic construction of anal canal. Release of adhesions. Recovered to gluteal skin. Plastic construction of anal canal. Release of adhesions. Recovered to gluteal skin. Plastic construction of anal canal. Release of adhesions. Recovered to gluteal skin. Plastic construction of anal canal. Release of adhesions. Recovered to gluteal skin. Plastic construction of anal canal. Release of adhesions. Recovered to gluteal skin. Plastic construction of anal canal. Release of adhesions. Recovered to gluteal skin. Plastic construction of anal canal. Release of adhesions. Recovered to gluteal skin. Plastic construction of anal canal. Release of adhesions. Recovered to gluteal skin. Plastic construction of anal canal. Release of adhesions. Recovered to gluteal skin. Plastic construction of anal canal. Release of adhesions. Recovered to gluteal skin. Plastic construction of anal canal. Release of adhesions. Recovered to gluteal skin. Plastic construction of anal canal. Release of adhesions. Recovered to gluteal skin. Plastic construction of anal canal. Release of adhesions. Recovered to gluteal skin. Plastic construction of anal canal. Relea	138,992	50		None		Recovered
140,136 29	112,679			None	Anastomosis of sigmoid to gluteal skin, Plastic construction of anal	Recovered
142,071 2 years Female 29 Appendicitis. None Appendectomy. Recovered Polythus of small intestine, post-operative with complete obstruction. Intussusception. Intussusception. Intussusception. None Reduction of intussusception. Recovered Partial research of 18 inches of ileum. Resection of 18 inches of ileum. Resection of Meckel's diverticulum and portion of the bladder. Partial resection of bladder. Partial research of bladder	83,307			None		Recovered
142,071 2 years Female Incarcerated right inguinal hernia with strangulation and gangrene of portion of ileum, Mckel's diverticulum and portion of the bladder. None Resection of 18 inches of Recovered ileum. Resection of Mckel's diverticulum. Resection of Mckel's diverticulum. Partial resection of bladder. Partial resection of bla	140,136	29	Appendicitis. Volvulus of small intestine, post-operative with complete	None	Exploratory laparotomy with	Recovered
143,637 Newborn Male Mal	142,071			None		Recovered
142,772 2 years Intussusception. None None Intestinal anastomosis. Recovered None Reduction of intussusception. Recovered None Recovered None Reduction of volvulus. Recovered None	897,06	56	hernia with strangulation and gangrene of portion of ileum, Mcckel's diverticulum	None	Resection of 18 inches of ileum. Resection of Meckel's diverticulum. Partial resection of bladder. Herniorrhaphy. Supra-public cystotomy.	Recovered
142,772 2 years Male M	143,637		Congenital atresia of ileum.	None	Intestinal anastomosis, Cecostomy, tube passed up through stoma of anastomo-	Recovered
14,067 Female colon with abscess formation and complete intestinal obscruction. 121,069 29 Intestinal obstruction due to adhesions from chronic perit to nitis of undertermined etiology. 144,036 Female 55 Female adhesions with volvalus. 139,802 6½ Male 128,938 32 Partial intestinal obstruction Male 128,938 32 Female due to adhesions. Recovered Closure of cecostomy. None Release of adhesions. Recovered episode of complete obstruction due to adhesions. Reduction of volvulus. Reduction of intussusception. None None None-Wangensteen suction with Levin tube relieved compressior.	142,772		Intussusception.	None		Recovered
121,069 29	14,067	61	colon with abscess formation and complete intestinal ob-			Recovered
144,036 55 Intestinal obstruction due to adhesions with volvalus. This was third episode of complete obstruction due to adhesions, requiring operation in the cavity almost obliterated. None Reduction of intussusception. Recovered 139,802 6½ Intussusception. Male 128,938 32 Partial intestinal obstruction Female due to adhesions. None None-Wangensteen suction with Levin tube relieved compression. Recovered None None-Wangensteen suction with Levin tube relieved compression.	121,069		Intestinal obstruction due to adhesions from chronic peri- tonitis of undertermined	None	Release of adhesions.	Recovered
139,802 6½ Intussusception. None Reduction of intussusception. Recovered 128,938 32 Partial intestinal obstruction None None-Wangensteen suction Recovered with Levin tube relieved compression.	144,036		Intestinal obstruction due to	episode of com- plete obstruction due to adhesions, requiring opera- tion. Peritoneal eavity almost ob-	sions.	Recovered
128,938 32 Partial intestinal obstruction None None-Wangensteen suction Recovered with Levin tube relieved compression.			Intussusception.		· ·	Recovered
	128,938	32		None	with Levin tube relieved	Recovered
	130,865	8 months	Intussusception.	None		Recovered

looked since no deaths occurred from other causes. Post-operative:

- (1) Wangensteen suction is again used in the postoperative period until distention subsides.
- (2) The intestine is kept at rest as far as possible with morphine at regular intervals.
- (3) Oxygen is usually a valuable adjunct during the immediate post-operative period
- (4) A proper fluid balance is maintained. The total serum protein is kept at normal level by use of plasma. Adequate amount of amino acids for mitrition are supplied intravenously. Glucose is given, using an isotonic solution, in order to preserve the vein.
- (5) Only a sufficient amount of sodium chloride is given for the daily requirement and to replace that lost by stomach suction. Wangensteen¹ has done extensive work in this respect, and from his report, it seems that as a general rule 1000 cc. of normal saline daily provides an adequate saline intake with stomach suction in place.
- (6) Large amounts of all of the vitamins are given parenterally.

(7) The usual post-operative regime of leg exercises and deep breathing is instituted.

Discussion:

Careful attention must be given to the daily intake of sodium chloride. If too much is given, subclinical or clinical edema will result, with the danger of acute pulmonary edema. Edema occurs early in the region of the operative incision and interferes with wound healing.

Another detail that requires constant attention is the protein level. The total serum protein must be maintained at normal levels by plasma and sufficient animo acids for nutrition supplied parenterally. Another check on fluid balance that will probably be of considerable value in the future is the dye concentration test of circulating blood volume.

SUMMARY

Some of the principals of operative treatment of intestinal obstruction are discussed.

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PEE DEE SOCIETY CENTENNIAL

The Pee Dee Medical Society (composed of physicians from the counties of Chesterfield, Darlington, Dillon, Florence, Horry, Marion, and Marlboro) will celebrate its centennial in Florence, October 14, 1948. Speakers at the scientific session (beginning at 3 p. m.) will consist of physicians born in South Carolina who have become outstanding in national medical circles. Those who are expected to speak are; Dr. Louis Buic of the Mayo Clinic, Drs. Oscar Bethea and Mims Gage of New Orleans, and Dr. Eugene Pendergrass of Philadelphia. Dr. Buie will also be the gnest speaker at the banquet which begins at

7:30 p. m.

Such records as are available show that the Pee Dee Medical Society was in existence in 1849 and that it was probably formed before that time. It thus antedates the South Carolina Medical Association, and is second only in age to the Medical Society of South Carolina (Charleston Medical Society) amongst the medical organizations of the state.

The Society extends a cordial invitation to all physicians throughout the state to attend the meeting. Those planning to attend should notify Dr. Rowland Zeigler, Florence, so that a place will be reserved.

The Iournal of the South Carolina Medical Association

EDITOR: Julian P. Price	Florence, S. C.
J. I. Waring Charleston R. M. Pollitzer Greenville	J. J. ChandlerSumter O. Z. CullerOrangeburg G. D. JohnsonSpartanburg

Please send in promptly notice of change of address, giving both old and new; always state whether the change is temporary or permanent. Original manuscripts, subject to approval by the Editor and the Editorial Board, are desired for publication in the Journal. They should be typewritten, double spaced, on 8½ x 11 paper. References should be complete, and only such as relate directly to statements quoted in the paper. Illustrations will be used as funds permit, or as authors are willing to bear the necessary increase in cost. Short original articles are preferred to long reviews.

Office of Publication: (In care of the Editor) Florence, S. C. Subscription Price \$3.00 per Year

SEPTEMBER, 1948

1086

As the directory goes to press we find listed 1086 members of the Association. This is an all time high. According to recent information received from the American Medical Association, there are in the neighborhood of 1550 living physicians in South Carolina. A number of these are colored physicians, others are internes in hospitals, and some are physicians who have given up the practice of medicine. After deducting this group, we estimate that ninety percent or more of those physicians who are eligible for membership in our Association are now members in good standing.

Assembling and arranging the data for the Directory has been no mean task. As this is being written, the final touches are being made, the lists are being checked and double checked, and it is hoped that the material will be in the hands of the printer within the next week. Every effort is being made to make this Centennial Directory an outstanding one. Whether a similar directory will be published each year from now on will depend upon the desires of the membership.

THE COUNTY MEDICAL SOCIETY

The county medical society has been and still is the keystone upon which our Association is built. Membership in the Association is contingent upon membership in a county society and no member can become a member of the Association until he first joins the county society.

We wish to stress this point because of a recent occurence in one of our county societies. A certain physician had been dropped from the roll of the society for a definite reason. Subsequently, he applied to the society for reinstatement. By a unanimous vote, the members of the society refused to accept his application. The physician in question is attempting to make an issue of the matter.

Under our constitution, the county society was completely within its rights. Chapter IX, Section 4 of the By-Laws states "Each county society shall judge of the

qualification of its members "But as this section continues " as such Societies are the only such portals to this Association and to the American Medical Association, every reputable and legally registered white physician whose work and conduct are of an ethical nature shall be eligible for membership." The next section reads, "Any physician who may feel aggrieved by the action of the society of his county in refusing him membership or in suspending or expelling him, shall have the right of appeal to the Council and finally to the House of Delegates."

In the case in question, the county medical society has done what the constitution gives it authority to do. Unless the physician in question wishes to make an appeal to the Council, no action may be taken by the Association.

SOUTHEASTERN REGIONAL CONFERENCE

Our Association is to have the privilege of serving as host to the Southeastern Regional Conference in Columbia during the early part of October. Two such conferences have been held, one last year and one several years ago, in Atlanta. To it will be invited officers and outstanding leaders from the state medical associations of Virginia, North Carolina, South Carolina, Georgia, Florida, Mississippi, Louisiana and Tennessee. In addition, invitations will be extended to some outstanding men, who are not physicians, interested in the medical problems of the people of the south.

It will be a two day conference. The first afternoon will be devoted to a discussion of the problems of the people in rural areas. The second morning will be spent in hearing different speakers, medical and non-medical, present the picture of health conditions as they exist in our southland. Following a luncheon, at which those in attendance will be guests of our Association, a round-table discussion will be held in an effort to find out the best means in which to meet and solve the problems which have been presented.

All members of the Association, particularly those who are officers of the Association or of county societies, or are members of special committees, are invited to attend. Detailed information will be sent out in a News-letter.

TWO GOOD LOCATIONS

Recently we have had two requests for aid in securing the services of a physician.

The first is from Mr. Cyrus T. Mims of Harleyville, South Carolina who writes; "The Giant Cement Company of Harleyville will start production sometime in October this year. The manufacture of cement here will create more activities and we, the Ruritan Service Club of Harleyville, are faced with a serious problem. We have no Doctor in our community. The nearest

one is twelve miles. We feel sure that your Journal can help us to locate a good physician."

The second letter asks us not to mention names, for justifiable reasons, but to insert the following notice: Wanted — A general practicing physician to locate in small community. Practice largely industrial. Hospital facilities nearby. Attractive arrangements for office and house can be made. Excellent opportunity for young doctor starting practice. Send inquiries to Editor of Journal. All inquiries will be handled on confidential basis."

If there is any member of the Association who knows of a physician to whom one of the propositions above might appeal, he is requested to ask him to get in touch with the Editor.

THE TEN POINT PROGRAM

ASSOCIATION SPONSORS BROADCASTS

Beginning September 1st, broadcasts of the series "Tell Me Doctor" sponsored by the South Carolina Medical Association, were commenced over five of the most powerful radio stations in the state. The stations, which are carrying the broadcasts as a public service, are WIS, Columbia; WCSC, Charleston; WTND, Orangeburg; WESC, Greenville; and WJMX, Florence. All, with the exception of the one at Orangeburg, are 5,000 watt stations. The series consists of fiveminute transcribed programs which are being broadcast, one each day Monday through Friday, each dealing with some subject of health and the prevention or treatment of human ailments, such as any new progress on treatment of cancer, tuberculosis and infantile paralysis; the effects of smoking; liver disease; and the dangers of over-exercise after the age of forty.

The series was prepared under the supervision of the Michigan State Medical Society, and broadcast originally over radio stations in that state. They have been used also, with general approval of the profession and public alike, by the Medical Society of Virginia. A more recent edition of the "Tell Me Doctor" series is currently being broadcast by 22 stations in Michigan.

For some time we have explored the possibility of such an activity by the State Association in South Carolina and it is believed that the use of the series, supervised and used by the profession of these other states, is the best means that could have been devised for reaching the public generally through the medium of radio.

The series is scheduled to continue for a period of twenty-six weeks.

Plans are still in the making for publication of a column of health news in the press of the state, especially in the county newspapers, most of which are published weekly.

REGIONAL CONFERENCE IN COLUMBIA

The Southeastern Regional Conference sponsored by the AMA Council on Medical Service, will be held in Columbia during the month of October. The fifth and sixth have been tentatively set as the dates for the two-day meeting.

Dr. Julian Price of Florence is Chairman of the Committee in charge of the arrangements and plans for the Conference. Other members of the Committee, which was named during the annual meeting of the AMA in Chicago in June, are Dr. Walter B. Martin of Norfolk, Va., newly elected member of the Board of Trustees of the American Medical Association, Dr. H. B. Mulholland of Charlottesville, Dean of the Medical School of the University of Virginia, who succeeded Dr. Martin on the Council on Medical Service, and the Council's Secretary, Mr. Thomas A. Hendricks, of Chicago.

The Conference last year was held in Atlanta and was well-attended by doctors from the Southeastern states. The program included very valuable contributions made by speakers not of the medical profession, but sympathetic with its interests and its views.

South Carolina and the SCMA are fortunate in having the Regional meeting scheduled for this state. It should focus the attention of the public briefly on the profession's awareness of the problems at hand, and on its liberal outlook in the efforts being made toward their solution.

DISTRICT PR COUNCILS

As a means to facilitate further the development of the Ten Point Program of the South Carolina Medical Association, more particularly as it relates to Public Relations, a plan is under consideration for organizing a group in each district of the state to cooperate with the central office. According to this plan,

which has been used successfully in other states, there will be established in each district a District Council or Committee headed by the Councillor of the district, and including likewise in its membership one representative from each County Medical Society in the district, and a physician representative also from any county in which there may be no organized Society.

Meetings of the District Councils would be held twice a year and otherwise, on call when the occassion may arise. It is believed, and experience has proved in other places where the plan is already in operation, that the establishment of such a permanent group as a nucleus for the activities of the State Association, will add greatly to its effectiveness, and make much easier the task of co-ordination of the efforts of the profession in reference to any activity which the Association may decide to undertake.

The District Councils or Committees will be organized definitely for action and not for scientific discussions. They will of course, not interfere with any existing organizations or activities of any county, district or other organization within the profession.

The plan, if approved by the Council of the State Association, is expected to be put into operation this fall and it is hoped that the district groups will be organized and working smoothly by the first of the year.

THE NURSING SHORTAGE—ACUTE OR CHRONIC?

(Editorial, NEW YORK MEDICINE, June 5, 1948)

It is obvious there is something essentially lacking in present day nursing to account for the acute shortage that exists in hospitals throughout the country.

At the end of the war *all* civilian professional help had been drastically diminished. That was almost three years ago. In other feminine career branches the return to normal has been attained. In nursing alone, the void is still present.

This country possesses about 300,000 graduate nurses plus another 90,000 student nurses who do active nursing while in training. Of the former group about 50,000 are not doing active nursing. While it is expected that a certain percentage will be lost to the profession by assuming other duties, it is interesting to note that approximately 30% of students—for the past three years—have been dropping out before graduation. At the present time enrollments are not up to par; there is no waiting list for women clamoring to attend nursing schools.

In addition, those who left civilian nursing for the Armed Services did not readily return to their former hospital positions. To make matters worse the increased gross national income plus the further public awareness of health problems has resulted in a demand and need for nurses that exceeds even the normal supply. This is especially so since more people than ever before are seeking hospital care.

Some of the reasons or factors responsible for this lack of nurse personnel can be stated, although not all are subject to any immediate or sudden solution:

(1) The increased census of hospital admissions is the most obvious. Even if our nursing ranks remained intact the shortage would still exist. With gross earnings increasing since the war, plus the popularity of "hospital plans" it is entirely possible that routine health problems which normally could be treated at home without nursing care are now being admitted to hospitals.

It would be necessary in this instance for the doctor to evaluate his cases with greater care from the standpoint of necessary treatment before advising "routine admissions". It is exasperating to the physician to have nurses tied up on a mild upper respiratory infection, while a pneumonia case goes partially unattended for lack of sufficient help.

(2) Greater economic reward for nurses might help towards solving the situation. The national average pay of general duty nurses is between \$170 and \$175 per month, working between 45 to 48 hours a week with no overtime. The monetary figure is not particularly attractive. This is especially significant when one considers the amount of training and schooling required. Girls of equal age and background, but less training, in other fields can easily outstrip their nursing sisters in earned income, hours of work, and, what's more important, opportunities for advancement.

In the time-honored profession of nursing it takes years to become a supervisor and at that the economic advantage is not tremendous. Unfortunately the supervisor of a diaper-service in a department store can make the same salary. It is not fair to compare the salaries of professional work with those of routine business jobs. The inequality of professional gains, not only in nursing but in medicine and teaching as well, is quite well known if not wholly appreciated. Effort could be made to increase the graduate nurses pay. This has already been accomplished to some extent in certain city hospitals but the amount is not great. If there was at least a hope of attaining two important objectives (1) the ability to earn a substantial living in the future or (2) a realization that even though the subsequent income may be limited, at least the prestige and complete professional respect of the job would be worthwhile and completely satisfying. This latter is really a question of dignity and it deserves careful consideration.

For example, it is taken for granted that in the medical profession per se, internes, assistant residents and residents serve their time with little or no financial reward. This they do gladly. Outside of the necessity for every doctor to avail himself of this clinical experience there is a certain prestige attached to securing





Formerly considered a tropical disease, amebiasis is more recently reported 1, 2 as "extremely common" and even "endemic" in this country.

Because early treatment has such an important bearing on prognosis, investigators stress the importance of prompt recognition through careful stool examination.

Destructive to the cysts of Endamoeba histolytica and especially valuable in sterilizing "cyst-carriers" is the high-iodine-containing amebacide, DIODOQUIN.

Diodoquin³ "is well tolerated....It can readily be taken by ambulant patients and, therefore, eliminates the necessity of hospitalization."



RESEARCH IN THE SERVICE OF MEDICINE

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the job. In the sister profession of nursing there always has been a similar prestige involved, but in the last few years it has noticeably waned.

Anyone familiar with commissioned nurse personnel during the war can testify that by and large at home and abroad the nurse occupied a rather desirable position. She was on an equal footing with fellow officers as well as medical officers. The privileges of her station and standing by virtue of her professional training were taken for granted. In ward work there was a corps of enlisted men to carry out the necessary routine jobs of ward cleanliness, maintaining supplies, making beds, carting travs and the other thousand and one chores that go into efficient hospital management. Therefore the nurse's job of earing directly for patients, the sick and the wounded, became paramount. Her position as a professional being, with specialized talent and training could be properly maintained; and more important, because of the emphasis on nursing, the position commanded respect.

In civilian hospitals that type of dignity does not prevail. There are insufficient maids and orderlies. Nurses are again forced to spend a lot of valuable time carting linen, drawing charts, flushing basins, or arranging amusing floral decorations. While every profession is saddled with its disagreeable tasks, in no other does it become so much part and parcel of the work that it becomes difficult to distinguish where the training ends and slavery begins. That sort of situation is not one to influence fine young women to give up other means of economic security and happiness because of the oft-repeated "dignity and tradition of the American Nurse."

As a contributory factor, the attitude of certain doctors toward nurses could be somewhat modified. The tendency of more than a few to regard the nurse as some sort of semi-educated domestic or an automatic instrument-dispenser, could well be discouraged. The nurses position in relation to the doctor is a difficult one at certain times, and that difficulty is not lessened by the assumption of a patronizing attitude or manner.

It is to the benefit of all that the nursing profession maintain its high moral and professional standing. Anything that contributes to that end should be the first consideration. The situation, at present, is acute, and there is a danger of it becoming chronic.

FOUR TYPES OF SURGERY ABSORB MAJOR PART OF BLUE SHIELD DOLLAR

Appendectomies, tonsillectomies, obstetrical and gynecological procedures account for approximately sixty cents out of every dollar paid to physicians by Blue Shield Plans for surgical services.

Beyond these major cost items, according to preliminary studies made by the Blue Shield national office in Chicago, approximately seventy surgical procedures will absorb eighty-five per cent of all payments to physicians for benefits provided under the average surgical type of subscriber contract.

Standard reporting forms are being completed by the Blue Shield national office, with the expectation that complete actuarial data for 1948 will be reported and tabulated by the middle of 1949, thus fulfilling one of the major functions assigned to Associated Medical Care Plans at the time of its incorporation in 1946

Payments for radiology and anaesthesiology services appear to be on the increase. Current explanations for this trend point toward the increasing number of physician specialists in these two fields of practice. Also, the incidence of these particular services seems to increase in direct ratio to the aging of a contract, or the Plan itself, during which time both the subscriber and physician become more aware of the benefits provided in the subscriber's contract and submit claims accordingly.

Female subscribers cost Blue Shield Plans approximately three times as much for surgical benefits as do male subscribers, while female dependents are only slightly less costly by comparison. Obstetrical and gynecological costs account for most of this difference.

Peculiarly, the female subscriber and female minor dependent have a high rate of utilization for appendectomies, while the female spouse has a lower than average utilization for the same service.

Female costs in the field of general surgery are above average, due principally to breast tumors.

Male dependents, chiefly minors, are more costly than female dependents of the same age, because of services such as herniotomies, circumcisions, fractures and dislocations. Boys seem to suffer exactly twice the number of broken bones as do girls.

MONTANA BLUE SHIELD RAISES INCOME CEILING TO \$5000

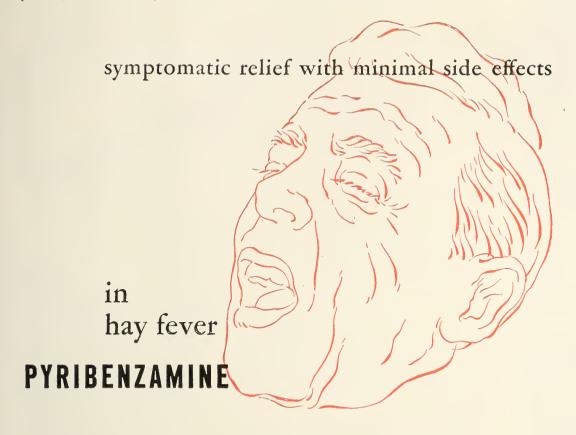
Service benefits for subscribers to Blue Shield in Montana were extended recently by raising the income ceiling from \$4,000 to \$5,000. Any member having a gross family income under \$5,000 per year will now receive all services provided by their membership certificate without being required to make additional payment to the physician.

More than 400 participating physicians have agreed to this liberalization in a realistic attempt to match inflationary trends and rises in living costs by extending the range of eligibility for service benefits.

Blue Shield Plans in California and New Jerscy have also raised their income limits for service benefits during recent months.

NON-PROFIT PREPAYMENT PLANS PASS 8,500,000 MARK IN SECOND QUARTER RECORD GROWTH

With most of the non-profit prepayment plans having reported their enrollment figures for the second quarter of 1948, the Blue Shield national office announced on August 1 that total enrollment had



During the last two pollen seasons, the effectiveness of Pyribenzamine hydrochloride in hay fever has been demonstrated repeatedly . . . 84% of 288 cases⁽¹⁾ -78% of 588 cases⁽²⁾ -82% of 254 cases.⁽³⁾

Side effects are few and for the most part mild: — "No serious side effects have been noticed in any patients." (1) "In our opinion, reactions to Pyribenzamine are minimal and seldom necessitate stoppage of the drug." (4) The usual adult dose is 50 mg. four times daily.

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Pyribenzamine Scored Tablets, 50 mg., bottles of 50, 500 and 1000. Pyribenzamine Elixir of 5 mg. per cc., bottles of 1 pint and 1 gallon.

• CIBA PHARMACEUTICAL PRODUCTS, INC., SUMMIT, NEW JERSEY





reached an estimated 8,624,911 members.

Second quarter growth was approximately 700,000 members, the largest quarterly growth ever recorded.

"At the present rate of growth, we expect the nonprofit plans to reach the 10,000,000 mark during the first quarter of 1949," reported Frank E. Smith, director of the Blue Shield national organization.

Michigan Medical Service reported 1,052,736 members enrolled at the end of the second quarter, 1948, becoming the first Blue Shield plan to pass the million member mark.

Organized in 1939, Michigan Medical Service began operations in 1940, being one of the oldest of the Blue Shield Plans, and for many years the largest such Plan in the United States.

"According to our enrollment records, we expect United Medical Service in New York City to become the second Plan to pass the million mark before the end of 1948," declared Lynn Doctor, assistant director and statistician for the Blue Shield national organization

MALPRACTICE ACTIONS

(Extracts from 'an address by Dr. Louis J. Regan, at the General Meeting of the Seventy-fifth Annual Session of the California Medical Association, Los Angeles.)

In all his life a physician suffers no greater shock than that of being sued for malpractice. Not uncommonly a defendant physician breaks, nervously and physically, under the stress and strain of a malpractice trial.

When a patient claims that he has suffered injury because his physician failed to care for him in a manner consistent with the usual and ordinary degree of skill and care commonly possessed and exercised by other reputable practitioners in the locality, he is accusing that physician of malpractice.

Any patient may bring a malpractice claim against any physician who has treated him. It is an easy charge to make; it is increasingly difficult to defend against such a charge.

World War I Experience

Following World War I, the malpractice claims incidence rose sharply, reaching epidemic proportions during the depression decade of the 1930's. Four thousand doctors of medicine were sued for malpractice in the United States in 1937.

The situation now threatens to become worse. The ground work is laid. Most of the people in this locality know about malpractice. They read in the newspapers and hear by word of mouth of judgments recovered by patients. The community as a whole is conditioned to the evil. Even a reference to an excellent hospital as a "murder mill" occasions no apparent shock. The wave of misunderstanding and ill-will engendered by the great number of malpractice actions has had a

cumulative effect, with increasing injury to the professional reputations of the individuals involved and serious deterioration of medical prestige in general. There is gathering in the minds of the public the idea that protection is needed against the profession. Will it be surprising if they seek it at the hands of the government?

Unjust Accusations

A further and a serious manifestation of the alarming malpractice trend is seen in the growing demand that criminal prosecution be initiated when to the uninformed lay view there appears to be some relationship between the death of a patient and the quality of professional attention which had been rendered in the particular case.

A physician should and must care for every patient with meticulous attention to the requirements of good medical practice. If he does so he cannot be justly charged with malpractice, but no course of conduct on his part will ward off the mjust accusation; and it must be recognized that many of the malpractice claims which are brought in this locality are not meritoriously founded. Furthermore, the defendant, in the majority of these cases, is not on the charlatan level but to the contrary, is among the most reputable of the group.

Every patient with a less than perfect end-result is a potential malpractice claimant. These days, when there is disappointment with the result, there will usually be some discussion whether to sue the doctor or not. Very little, if any, additional stimulus is required to precipitate a suit.

Idealism and Practicality

No one of us is immune to a malpractice action. We have been right to expect that the physician who practices good medicine, who renders sufficient and careful attention in all the circumstances of his cases, who deals with his patients fairly and honestly at all times, would be safe from the charge that he is lacking in skill and knowledge or in professional integrity. I say that we were right in our attitude; that it was natural and proper, in harmony with the unselfish preoccupation of the physician with the well-being of his patient. But it is time for a change,—a change from naive idealism to aggressive practicality, if we wish to protect our professional reputations and to stay the deterioration in the public's confidence in the profession.

PEE DEE SOCIETY PLANS

(Other Districts Please Note.)

The Pee Dee Medical Society has planned a unique program for its regular meeting on September 16th. The meeting place, which is rotated, this month is the capital of the Pee Dee, Florence.

In addition to the members and their guests, the

"Much has been done, much remains to do, a way has been opened, and to the possibilities in the scientific development of medicine there seems to be no limit."

SIR WILLIAM OSLER, Aequanimitas

As yesterday's therapeutic triumph becomes today's routine procedure, physicians everywhere look forward to the revelations of the future. The perfection of today's resources and the expedition of those of tomorrow are the unremitting aims of Schering Corporation, manufacturers of hormones, chemotherapeutic agents, x-ray diagnostic media and other pharmaceutical products.

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pharmacists of the Pee Dee section have been invited to attend as guests of the Society, and each physician was asked to bring with him one of the non-professional leaders of his community. Other Society guests also have been invited and a meeting of medical and non-medical men in an atmosphere of general good-will is planned.

ABSTRACTS

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During anaesthesia a patient becomes more susceptible to the effects of unphysiologic positions because he is unable to complain of postural insults which normally he would not tolerate.

Brachial plexus injuries may be produced by hyperextending the arm on a board, as is sometimes done for axillary surgery, for infusions, or to make room for an assistant. Shoulder braces, while being used for Trendelenberg position, cause injury unless placed over the bony acromioclavicular joint rather than the soft structures of the supraelavicular space.

Radial, ulnar, and median nerves are vulnerable when the arm of the anaesthetized patient is allowed to press against firm objects such as the edge of the operating table and a fixed anaesthetic screen.

Leg braces and stirrups used with lithotomy position may cause pressure on the common peroneal nerve or saphenous nerve with subsequent foot drop or paraesthesia. The degree of nerve paralysis varies in time from a few hours to permanent disability.

Any position causing nerve injury may also cause blood vessel damage and ischemia to the related parts if the abnormal position is maintained long enough to cause tissue damage. The relation of nerve and vascular injuries to the number of anaesthetics given yearly is small; however, the fact that these injuries are preventable makes even a few regrettable.

This type of nerve injury is treated principally with physio-therapy. In some cases of vascular injury, sympathetic nerve block is valuable. Prevention of injury due to malposition is the responsibility of both the anaesthetist and the surgeon.

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Ingestion of Mercury as a Probable Cause of ACRODYNIA, and Its Treatment with Dimercaprol (BAL), Report of two cases.

Samuel E. Elmore, M. D. Pediatrics, May, 1948 (Vol. 1 #3).

These two articles present in the literature for the first time a logical explanation of the etiology of acrodynia, and give laboratory proof of the hypothesis. In addition they point out an apparently dramatic cure which was effective in the three cases presented within eleven days, in contrast to the protracted course that the disease has characteristically run in the past.

These articles also stress the fact that this disease is relatively common in the piedmont section of the southeastern U. S. A.

The symptoms are also stressed as follows:

The disease occurs most commonly during the second half of the first year. It is characterized by gradual onset of fretfulness, restlessness, insomnia, and anorexia. The hands and feet become deep pink, are swollen, moist, cold, tender, and tend to desquamate, a generalized dusky maculopapular rash appears over the body, and there is profuse sweating. The muscles are very flabby and reflexes are diminished. The patient is often described as being "floppy". Photophobia is almost always severe, and as Dr. Bivings points out in his case this was due to an iritis, and was the last symptom to disappear after treatment. The gingivae are swollen and teeth often fall out. Hypertension and tachycardia often are present. Itching of the hands and feet is so severe that often permanent scars result from scratching.

The authors mention that Dr. J. Warkany of the Children's Hospital of Cincinnati first discovered mercury in the urine of these patients.

Mercury was demonstrated in the urine of the 3 patients reported in these two articles in amounts more than 10 times normal. A history was obtained in one case that the infant was given calonnel and rhubarb by the family physician in 12 doses some weeks before admission. The other two cases had been given "a few" teething powders, each subsequently found to contain 3.5 mg of mercurous chloride (calonnel) less than a week preceeding the onset of the illnesses.

Treatment consisted of freeing the patients of mercury by use of the new compound BAL.

The drug was given in dosage of 2.5 to 3 mg. per Kg. body weight every four hours for 48 hours then every six hours for 24 hours, then every 12 hours for seven days. (Each injection as BAL in oil 10% with novocain 2%).

Reduction in amount of mercury in the urine occurred in 6 to 9 days in the 3 cases. Symptoms began to subside also on an average of the fifth day of treatment and patients were considered completely well by the eleventh day.

(One is tempted to wonder why acrodynia is not more common if calomel is the causative factor. Ed.)

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Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154, Laryngoscope, Jan. 1997 Vol. XLVII, No. 1, 58-60; Broc. Soc. Exp. Biol. and Med., 1934, 32-241, N. Y. T. L. Lovy, Mr.d., Vol. 1, 7-1-25, N. . II, 190-592

^{*}Completely documented evidence on file.

^{* *} Reprints on request:

DEATHS

CHARLES WILLARD MIMS

Dr. Charles W. Mims, 30, died suddenly from a heart attack on the morning of July 24, in Greenville. He was driving his car in answer to a call when he was stricken.

A native of Florence, Dr. Mims received his education in the schools of that city and at Furman University and was graduated from the Medical College of the State of South Carolina in 1943. He served his interneship at the Greenville General Hospital and had practiced in Greenville since that time.

Dr. Mims is survived by his widow and one son, Charles Willard Mims, Jr.

NEWS ITEMS

The South Atlantic Association of Obstetricians and Gynecologists announces the establishment of 'The Foundation Prize.' Authors of papers on Obstetrical or Gynecological subjects desiring to compete for the prize may obtain information from Dr. E. D. Colvin, Secretary-Treasurer, 1259 Clifton Road, N. E., Atlanta, Ga.

Druggists and the medical profession were urged today by the Federal Security Agency's Food and Drug Administration to return all stocks of Siliform Ampuls to the manufacturer, The Heilkraft Medical Company, Boston, Mass. This injection drug, which should be sterile, is potentially dangerous since samples collected on the market contain living organisms. Siliform is injected by some physicians and osteopaths in the belief that it will relieve patients suffering with rheumatism as claimed by the manufacturer. The Food and Drug Administration found the contaminated samples after a routine inspection at the Heilkraft factory disclosed that the Siliform Ampuls had been manufactured without sterilization. Intensive recall efforts by the manufacturer and the Food and Drug Administration for the past two weeks have not brought in all of the contaminated stocks. The article, which moves slowly, was shipped to 37 states from Maine to California and later was redistributed by wholesalers who cannot trace many of their sales. Some going back as far as 1946 have been found on the market. These ampuls may be in the hands of doctors, hospitals, clinics, and retail and wholesale druggists.

THE 5 SOUTHEASTERN STATES NEED 106 VA PHYSICIANS

Branch Office No. 5 of the VA, Atlanta 3, Ga. has appealed to the internists of the United States to help them staff the 17 hospitals under their jurisdiction. There are abundant opportunities for physicians who are qualified in internal medicine and the subspecialties to head services and sections in these hospitals which are located throughout the southeast from Johnson City, Tennessee to Tuscaloosa, Alabama, and from Memphis, Tennessee to Coral Gables, Florida.

In addition to openings for specialists, there are also abundant opportunities for young men who have finished their residency training, and, who now need two or more years of preceptorship training, under certified internists, with teaching ability, where they may make their final preparation in an academic atmosphere for completion of the American Board requirements.

The organization plan of all of our hospitals follows the outline prepared by the Council on Medical Education and Hospitals published by the American Medical Association (J.A.M.A. 113:794, Aug. 26, 1939). Emphasis is placed on bedside instruction, teaching rounds, seminars, clinical-pathological conferences, demonstrations and lectures. All of our hospitals are affiliated with nearby medical schools for educational purposes and twenty qualified Branch Consultants, covering every specialty in Medicine and Surgery, pay periodic visits to the hospitals for teaching and supervision of the professional service in their respective fields.

All of our hospitals possess large well-equipped laboratories and libraries. All new modern textbooks and an average of 100 current journals are available to the staff doctors. Opportunities for research and study are splendid. Every possible consideration is given to the encouragement and stimulation of clinical investigation and professional advancement. Attendance at conventions and postgraduate courses is approved on official leave. Excellent bibliographical and medical illustration service is available to all of our doctors upon request.

Salaries, while they are not high, the upper limit being \$11,000.00 per year, are adequate for those physicians who are primarily interested in professional advancement, an opportunity to contribute to the medical literature, or who liave an overwhelming desire to practice top-flight medicine in an atmosphere of professional freedom.

There are other advantages to participation in the new Department of Medicine and Surgery of the VA including 30 days of annual leave and retirement privileges, but the greatest inducement of all is the ability to practice first class medicine without being hampered by the inevitable consideration of the cost of medication, special examination and laboratory procedures, consultation service or lengthy hospitalization, such as inevitably affects the character of professional services rendered by the civilian physician in private practice. Satisfaction in the splendid service rendered to worthy veterans and their heartfelt gratitude expressed to the physician undoubtedly plays a great part in the professional morale so high in our hospitals. There has been a great improvement in every phase of hospital service since the renaissance spear-headed by Dr. Paul R. Hawley and promoted, expanded, and brought into full-flower through the efforts of our present Chief Medical Director, Dr. Paul B. Magnuson.

Dr. Wallis D. Cone has announced the opening of his office for the practice of urology at Tuomey Hospital, Sumter.

Dr. Charles E. Carpenter is now associated with his brother, Dr. William McN. Carpenter, in the practice of ophthalmology and otorhinolaryngology at 202 East North Street, Greenville.

Dr. Ethel M. Madden of Columbia has been certified by the American Board of Pediatrics. The examinations were held in Cleveland, Ohio, in April, 1948

Dr. John C. Bonner is now associated with Dr. B. Owen Ravenel in the practice of pediatrics, 95 Rutledge Avenue, Charleston.

Dr. Frank Woodruff, formerly of Greer, is now assistant resident in obstetrics and gynecology at General Hospital, Greenville.

BIRTH ANNOUNCEMENT

Dr. and Mrs. W. J. Jenkins of Olanta are receiving congratulations upon the birth of a daughter. Kathleen Louise, on July 20th.

WOMAN'S AUXILIARY SOUTH CAROLINA MEDICAL ASSOCIATION

President: Mrs. P. M. Temples

Publicity Secretary: Mrs. William H. Folk

Dr. R. B. Durham, Columbia, South Carolina has appointed the following physicians to serve this year on the Advisory Council of the Woman's Auxiliary to the South Carolina Medical Association:

Dr. Vance W. Brabham, Sr., Orangeburg, S. C.,

Dr. William H. Folk, Spartanburg, S. C.

Dr. J. L. Sanders, Greenville, S. C. Dr. W. L. Pressley, Duc West, S. C. Dr. J. A. Siegling, Charleston, S. C. Mr. M. L. Meadors, Florence, S. C.

We feel sure that under these physicians' capable leadership the work of our Auxiliary will continue to progress.

MEETINGS-

Mrs. Powell M. Temples, President, Woman's Auxiliary to the South Carolina Medical Association, will be guest speaker at luncheon meetings of the Greenville and Anderson Auxiliaries in September. Mrs. William H. Folk, Publicity Secretary, will accompany Mrs. Temples to these scheduled meetings. SOUTHERN MEETING:

Preparations are being completed for the annual meeting of the Woman's Auxiliary to the Southern Medical Association which will convene in Miami. Florida, October 25-27, 1948. Headquarters will be at the Columbus Hotel.

Mrs. Olin S. Cofer, President, from Atlanta, Georgia, will preside. Mrs. Cofer is very pleasantly remembered by members of the Woman's Auxiliary to the South Carolina Medical Association as she was an honored guest at our annual convention held in Charleston, S. C. Mrs. R. F. Stover, Miami, Florida will be Conven-

tion Chairman.

Physicians wives planning to attend the Southern Meeting are asked to register as soon as possible after arriving in Miami. Mrs. Temples will appreciate your advising her if you plan to attend the Convention.

Mrs. David F. Adcock from Columbia, S. C., im-

mediate past state president, has been invited to give the Response for Auxiliary Members at the Convention of the Woman's Auxiliary to the Southern Medical Association.

BOOK REVIEWS

Textbook of the Nervous System-A foundation For Clinical Neurology—H. Chandler M.A., Ph.D.—J. B. Lippincott Company.

This is a new technique for the preparation of a text on Neurology. Beginning Part I with an explanation of the purpose of this new idea, Dr. Elliott has made a big step forward in helping the medical student and the graduate student to understand the mechanism of the nervous system in relation to the practice of medicine.

The authors' diagrams, which are numerous and clearly labeled, are appropriate pillars to rest on as

the text is studied.

Part I seems to be quite adequate in its purpose of laying a ground-work for the students' clearer under-

standing of the study of neurology.

In Part II the nervous system is considered in detail with sufficient wordage on each part from the neuron up to the cerebrum and cerebellum as complete units.

Of special interest to the reviewer was the set of photographs showing sections of the brain and accompanied by key drawings to point out the areas of

gross neuroanatomy.

All in all the book is about as "refreshing" a coverage of the subject as the reviewer has encountered. It is highly recommended to the medical student and surgeon alike.

Well-paying unopposed general practice available in small South Carolina town. Will introduce. Without cost to right man. New office building as well as dwelling house (next door). Available October 1, 1948, Practice consists of farm and industrial workers.

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ANTI-MALARIA DRUG EFFECTIVE IN TULAREMIA, UNDULANT FEVER

Atabrine the drug which, developed in Germany, was the principal reliance for malaria control in the Pacific and Mediterranean theaters during the war, may be effective in controlling undulant fever and tularemia, a Vandalia, Ill., physician reports.

Writing in *The Illinois Medical Journal*, official publication of the Illinois State Medical Society, D. H. Ecke, M.D., of Vandalia, and Dean H. Ecke of the Illinois Natural History Survey, Urbana, described eight cases of tularemia and four cases of undulant fever which Dr. Ecke successfully treated with atabrine.

Tularemia, which has become increasingly important in recent years, is usually transmitted to man from infected wild rabbits, while undulant fever, or brucellosis, is contracted either by handling diseased cattle, hogs, sheep or goats or eating unpasteurized dairy products from herds infected with contagious abortion or Bang's disease, as brucellosis is known in cattle.

The tularemia cases included in the report were all treated up to April, 1948. Typical was a 65-year-old woman who, at the time of examination by Dr. Ecke, was "suffering with fever and chills."

"She had an ulcer on her right thumb, and the lymph gland under her right arm was considerably enlarged and very tender," the report disclosed. "These symptoms strongly suggested a case of ulceroglandular tularemia.

"Further inquiry brought out some important facts:

"She had dressed some freshly killed wild rabbits (cotton-tails) about three weeks previously—about a week before her illness started. Two or three days after she had dressed the rabbits, a primary papule (sore) developed on the right thumb. This papule would not heal and developed into the persistent ulcer noted above."

Dr. Ecke prescribed atabrine to be taken three times daily for five days.

"At the end of the fifth day, she reported back for examination," the report continued. "She said that the chills and fever had left on the second day with no recurrence. Examination showed lymph glands normal and the ulcer nearly healed, with no infection evident. She has had no recurrence of the symptoms since."

Similarly, the report stated, seven other patients were treated "who showed the typical symptoms of ulcero-glandular tularemia as described above."

"Every case was traced to the handling of rabbits a few days before," the report added. "The characteristic chain of symptoms followed. Without exception, atabrine produced a favorable response within one to three days and not one case required further treatment after the fifth day. In none of these cases has there been a recurrence of symptoms."

Dr. Ecke employed the same treatment in four undulant fever cases, diagnosis of which in three cases was confirmed by laboratory study of blood. In these cases, all symptoms of undulant fever disappeared within five days after atabrine was started. One patient relapsed after almost five years, but recovered after two or three days of atabrine treatment.

Although the organisms responsible for brucellosis, or undulant fever, have been known for more than 60 years, there has been no positive treatment for the disease. The sulfa drugs and penicillin proved disappointing and so did streptomycin, although recently a combination of streptomycin and sulfadiazine has been reported successful. Against tularemia, streptomycin has been much more successful. However, the drug has its limitations. It is expensive and it may produce unfavorable side reactions, such as damage to cranial nerves, causing loss of balance. Also its continued use may produce a resistance against itself rendering it ineffective if needed at some later date.

Commenting on the series of patients treated with atabrine for undulant fever and tularemia, Dr. Ecke painted out that "none of the patients was able to afford streptomycin nor was the drug available in most cases."

"Experimentation with atabrine has given us very favorable results in all cases of tularemia and undulant fever in which it was used," the report concluded. "It is now a question of whether this treatment will give positive results when extensively used.

A. M. A. MEETING

Registrations and hotel reservations are now being accepted for the second annual Interim Meeting of the American Medical Association at St. Louis, November 30 to noon, December 3, 1948.

On the eve of the Interim Meeting, Saturday, November 27, the first national Medical Public Relations Conference will be held under sponsorship of the A. M. A. at the Statler Hotel.

Planned to be especially valuable to the general practitioner, the Interim Session will offer lecture meetings, conducted by medical leaders on conditions most often seen in daily practice. Subjects to be discussed include diabetes, heart disease, cancer, poliomyelitis, obstetrics, pediatrics, dermatology, genitourinary conditions, hypertension, anesthesia, tuberculosis, jaundice, laboratory diagnosis, x-ray diagnosis, and physical medicine as applied to the treatment of arthritis.

Diagnosis and treatment will be stressed in a wide variety of clinical conferences, which will be correlated with the lecture meetings. Leading practitioners from all sections of the nation will conduct these conferences.

Evening programs will feature distinguished speakers, the award of the general practitioner medal, and fun. Entertainment will be provided, free of charge to physicians and their guests of course, by stars of the amusement world.

A scientific exhibit with nearly 100 displays will show clinical and pathological material on subjects dealt with in the clinical conferences.

Approximately 115 leading firms will display technical exhibits, which will include new products, equipment, and medical publications. All exhibits will be open from Tuesday at 8:30 a.m. to Friday noon, November 30 to December 3.

Papers will be read at the General Scientific Meetings in the St. Louis Opera House from 9 to 10 a.m. and from 2 to 3 p.m. each day. At least six demonstration units are planned for each half day in the Scientific Exhibit from 10:30 a.m. to 12 noon, and from 3:30 p.m. to 5 p.m. Small rooms will be pro-

vided for these demonstrations and provision is being made so that physicians can take all the notes they wish in comfort.

Intermissions in the program will be from 10 to 10:30 a. m., 12 noon to 2 p. m., and 5 p. m. to 6 p. m. each day.

Officers and members of the House of Delegates will stay at the Statler Hotel. Those attending the Medical Public Relations Conference will stay at the Lennox Hotel.

A registration form which enables the physician to save time by securing a registration card in advance is appearing in The Journal of the American Medical Association every other week until the Interim Meeting. A convenient blank for making reservations at number of St. Louis' best hotels, which are within easy walking distance of the St. Louis Auditorium, is also printed in The Journal.

All reservations must be cleared through the Chairman, Subcommittee on Hotels, American Medical Association, Hotel Reservation Bureau, 1420 Syndicate Trust Building, St. Louis 1, Mo., and must be received before November 9, 1948.

JOURNAL ANALYZES USE OF STREPTOMYCIN IN TREATMENT OF TUBERCULOSIS

"Streptomycin provides an excellent medium of treatment for certain types of tuberculosis, says the current issue of *Radiology*, but adds that it "should be withheld in cases of minimal tuberculosis and in those in which conventional treatment offers reasonable prospects of good result."

The Journal *Radiology*, says editorially that streptomycin "should be used in association with accepted therapeutic measures and not as a substitute for them."

"As a matter of fact," the editorial says, "a healthy tendency is at present developing to use the drug only as an adjunct rather than as a definitive treatment in all types of tuberculosis except the miliary and meningitic forms, to apply it briefly for three, four or six weeks, at the most opportune time, with other appropriate therapy."

The article states that despite the tremendous volume of careful work by research scientists, "the disease has remained persistently resistant to attack," adding: that "no specific and no cure has yet stood the test of time, although hundreds have been offered. Of these, only one has shown the capacity to influence the disease in man—streptomycin."

The editorial states that the new antibiotic drug "should be tried in all cases of miliary tuberculosis, for more than half of such patients will be alive, and a substantial number of them will be free from clinical, x-ray, or laboratory signs of disease, six to twelve months after discontinuation of the drug."

Continuing, the editorial says in part:

"The use of the drug in tuberculosis meningitis is mandatory, for about one-fourth of all patients have survived from six to twelve months after treatment, and the majority of these are free from detectable signs of tuberculosis.

"Extrapulmonary tuberculosis is under detailed study, but already it appears that tuberculous laryngitis and bronehitis are benefited by the use of streptomycin in about 85 per cent of cases, even though the parent lesion in the lungs may show no improvement.

"Streptomycin is used profitably at times to enhance the patient's chances from collapse therapy and as a prophylactic in surgical treatment, particularly pulmonary resection.

"In the face of these relatively good results, a disturbing fact is that the average case of fibrocavernous tubereulosis has been found to respond poorly to streptomycin, and this type represents three-fourths of all cases of the disease. It is still under intensive study."

Borden Company

OUR ADVERTISERS

We wish to call to the attention of our readers the names of those firms which have contracts with us for advertising during 1948:

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Calcareous Pancreatitis And Diabetes

THE REPORT OF A CASE

F. Macnaughton Ball, M. D. Charleston, S. C.

Chronic pancreatitis is the term used to describe varying degrees of acquired fibrosis of the pancreas with increase of the interstitial connective tissue more or less replacing the parenchyma of the gland. Two types of pancreatitis were described by Opie.1 The first of these is the interlobular type in which the increased fibrous tissue is limited to the tissues between the lobes of the parenchyma and in which diabetes is said to be very rare. The second is the interacinar type in which the connective tissue invades the interacinar spaces with progressively advancing sclerosis, replacement of the parenchyma, and destruction of the isles of Langerhans late in the process. Advanced fibrosis of this type is frequently associated with diabetes mellitus. Chronic pancreatitis is not an uncommon incidental finding at autopsy or surgery in elderly patients, but is rarely diagnosed or suspected in the living patient.

Deposition of calcium salts in the substance of the pancreas is rarely encountered. Pancreatic calculi were first described in Europe by de Graff in 1667. By 1942 two hundred and fifty cases of true pancreatic lithiasis had been reported in the literature. Recent case reports by others bring this total to 285.3-11

Two types of pancreatic stones were described by Mayo. 12 These are the (a) true stones found in the pancreatic ducts and (b) false stones or calcifications of the parenchyma resulting from pancreatitis. The first type may be the cause of colickly pain and surgical intervention may be sought. The second type is not in itself a cause of pain and is less often diagnosed. Dozzi and Bockns2 in 1943 found reports of 18 cases of diffus calcareous pancreatitis. The recent case reviews of chronic relapsing pancreatitis from the

larger clinics⁹⁻¹¹ suggest that clearcut differentiation between duct stones and diffuse calcification of the parenchyma is not of clinical significance in the diagnosis of the primary disease, but in reality, are both manifestations of chronic recurrent pancreatic inflammation.

Another patient exhibiting diffuse calcification of his pancreas accompanied by diabetes mellitus, steatorrhea and transient jaundice has been recently studied at Roper Hospital. Because of the sceming rarity of this syndrome it is believed worthwhile to publish the observations made in this patient in some detail.

Case Report

Mr. 11. C., a 43 year old white male was admitted to Roper Hospital because of weakness and glycosuria on 26 September, 1946.

Four months prior to admission the patient had been hospitalized elsewhere for treatment with symptoms of chills and fever, acute generalized abdominal pain which was most severe in the left upper quadrant, mid-epigastrium, and left costovertebral angle, nausea and vomiting. Jaundice appeared in the second week of his illness. He was treated with quinine and glucose infusions and was told he had sugar in his urine as a result of the infusions. After 15 days of hospitalization he was discharged. He continued to feel weak and continued to lose weight. At the time of admission he found that he had lost 32 pounds in 56 days. For three weeks prior to admission polyuria and pdydipsia had been present. Glucose was found in the patient's nrine on routine urinalysis in the outpatient clinic and he was admitted for study,

The patient was a leadburner. There was no known contact with tuberculosis and no relative was known

⁽From the Department of Medicine of the Medical College of the State of South Carolina and the Roper Hospital, Charleston, South Carolina.)

to have diabetes. He gave a past history of mumps, pleurisy, and malaria in 1928. He had been edentulous since 1937. For many years he had suffered pyrosis, often relieved by cructating, after meals and at night. He had seldom vomited and prior to his present illness had never had abdominal pain. His bowel habits and stools had been normal. Before the onset of his present illness he usually drank about 1 pint of whiskey daily.

Physical examination showed a white male of 5 feet 8 inches height and 119 pounds weight, with a temperature of 99.6° F., a pulse of 88, respiratory rate of 20, and a blood pressure of 124 90. He appeared chronically ill, weak, and showed evidence of weight loss. There was no icterus of the skin or sclerae. All teeth had been extracted and replaced by plates. The axillary lymph nodes were palpable but not enlarged. The lungs were clear to percussion and ausculation. The heart was not enlarged and there were no arrhythmias or murmurs. The abdominal wall was flat and relaxed with no palpable masses, organs, or evident tenderness. There was no costo-vertebral angle tenderness. The genitalia were normal and rectal examination revealed a normal prostate and rectal pouch.

Laboratory data: The urine showed a 4 plus reaction for sugar and a negative reaction for acetone. The blood erythrocyte count was 4,800,000, the hemoglobin 12.0 gms. The white blood count was 8.500 with a differential count of 55% polymorphonuclears, 35% lymphocytes, 5% monocytes, 2% eosinophiles, and 3% basophiles. The fasting blood sugar was 298 mgm %; the blood urea nitrogen 23 mgm %, the icterus index 4. A blood smear for plasmodia was negative and no basophilic stippling of the red cells was noted. Serum agglutinations for the common febrile diseases were not diagnostic. The Wassermann and Kline tests were negative. The stools were claycolored, slightly greasy, and revealed on microscopic examination the presence of an unusual quantity of fat globules.

A plain film of the abdomen revealed a large number of small rounded calcific densities arching across the upper abdomen interpreted by the radiologist as probable calcifications in the panereas.

On direct and repeated questioning the patient again denied any change in bowel habits, but questioning of his wife revealed that for at least 4 years the patient had frequently had diarrhea of copious, fatty stools; that he was unable to control his oily bowel movements and would pass greasy fecal material in his underwear or in bed. She stated that his stools were so laden with oil that the toilet bowl had to be cleaned with lye and that the water in the bowl was covered by a layer of oil droplets following the passage of a stool. She volunteered the information that the patient had consumed during the four years of their marriage "as much alcohol as a man could take." His alcoholic bouts were always followed by increased steatorrhea.

A gall bladder x-ray examination showed impaired function manifested by failure to empty after a fat meal. The gall bladder was empty 24 hours later.

A barium meal aided in localizing the calcification throughout the length of the pancreas and revealed no evidence of peptic ulcer, inflammation or malignancy of the csophagus, stomach or duodenum.

The serum amylase was 16 and 32 units per 100 cc. on two determinations. The serum cholesterol was 156 mgm. %, calcium 9.1% mgm., phosphorus 4.8 mgm. %, total protein 7.48 gms., albumin 5.29 gms., globulin 2.19 gms.

Duodenal suction with a Miller-Abbott tube was attempted. The tube was seen on fluoroscopy to be lying in the second portion of the duodenum but all of the specimen obtained was of high free acidity, not bile stained, and no pancreatic amylase was found on titration. The patient would not permit passage of the tube a second time.

Course In The Hospital:

The patient's diabetes was controlled on a diet of relatively low fat content. An insulin mixture of 10 units of protamine zinc insulin and 20 units of regular insulin was given once daily before breakfast. On this regime his steatorrhea was well controlled and he was discharged 63 days after admission with a weight gain of 5 pounds.

The patient has been followed in the out-patient clinic for more than a year. He continued to gain weight until he had returned to his usual weight of 150 pounds. After 8 months he was able to keep his urine sugar free by diet alone and with careful regulation of his fat intake was able to minimize the steatorrhea. Insulin was not necessary for five months. Then his work required him to move to a nearby town where his diet was not well managed and he again began to drink moderately. Insulin has since been necessary to keep him regulated.

Discussion

The following diseases associated with chronic pancreatitis are listed by most authors: Chronic alcoholism, chronic disease of the biliary system, occlusion of the main pancreatic duct by calculus or carcinoma, arteriosclerosis, gastritis, duodenal ulcer, duodenitis, acute pancreatitis, syphiliseand tuberculosis.

Supposedly most important in the pathogenesis of chronic pancreatitis are alcoholism and longstanding infection of the biliary tree. Infection is believed to extend to the pancreas by way of the pancreatic lymphatics. Approximately two thirds of the patients with pancreatitis have cholelithiasis and one fourth of the patients with gall bladder disease have some pancreatitis. 2 Of 36 autopsies on patients with chronic pancreatitis at the Boston City Hospital, 12 had chronic cholesystitis and 7 had cholelithiasis.13

The series of patients reported by Comfort, et al,9 had chronic pancreatitis associated with no other disease of the gastrointestinal tract.

The percentage of chronic alcoholics among patients with acute and chronic pancreatitis and panereatic lithiasis reported in the literature is strikingly high. Clark, 14 reported in 1942, a series of 36 autopsies in alcoholie patients with pancreatitis none of whom had gall bladder disease. He concludes that the role of the prolonged alcoholic debauch overshadows, by far, that of chronic gall bladder disease, in the pathogenesis of pancreatitis. At any rate, it is well known that chronic alcoholics are unusually susceptable to disease of the organs of the upper gastrointestinal tract. Alcohol seemed of little importance, however, in the development of chronic pancreatitis in a series of patients with this disease reviewed in January, 1948 by Maimon, et al. Only 2 of their patients would admit to chronic alcoholism, 11

The majority of patients with chronic pancreatitis are between the ages of 40 and 50 years and the incidence in males is higher than females, despite the greater incidence of gall bladder disease in females.

There is no clear-cut symptom complex in chronic pancreatitis and it is for this reason that the disease is confused with other conditions. There may be intermittent seizures of pain in the epigastrium lasting for hours or days with radiation to the back or between the scapulae. The pain is sometimes exceedingly severe and may be taken for gall bladder colic. Dyspepsia with bloating and belching is frequently a complaint. Steatorrhea of varying severity may be present with production of large, foul-smelling, pale, glistening, greasy or oily stools of acid reaction and with microscopic evidence of increased undigested muscle fiber. There is usually fairly marked weight loss. Jaundice is absent in most cases but a history of intermittent jaundice may be obtained. A slowly progressive jaundice due to obstruction by fibrosing pancreatitis has been reported. The glyeosuria of diabetes when present appears late in the disease following extensive destruction of the gland. X-ray evidence of pancreatic lithiasis or diffuse calcification is responsible for accurate diagnosis in an increasing number of cases as it was in the case reported here.

Pancreatic lithiasis appears to follow and accompany pancreatitis and the same factors play a part in its pathogenesis. Calcium carbonate and tribasic calcium phosphate are the chief constituents of these stones. Pancreatic secretion is said to contain very little of these salts. It is thought that inflammation and infection alter the chemical composition of the pancreatic juice in some way permitting the deposition of these salts. It is also believed, that in areas of acute fat necrosis fatty acids split from neutral fat by lipase combine with calcium to form soaps. This is probably the mechanism involved in diffuse pancreatic calcification. Large amounts of calcium are mobilized in the pancreas in areas of fat necrosis. 15

Diagnosis is aided and confirmed by certain laboratory procedures the most important of which is the study of the duodenal secretions for quantitative determination of the pancreatic enzymes; amylase, lipase, and trypsin. In chronic pancreatitis these may be absent or greatly reduced in amount. Gross, microscopic and quantitative evidence of increased fat and protein in the stool is present if the patient is suffering from this disease. Diminished or absent pancreatic enzymes in the stool support the diagnosis. Quantitative determinations of serum amylase are not of assistance in chronic pancreatitis unless the patient is having an acute exacerbation of the disease with increase in serum aunylase. After the subcutaneous injection of a pancreatic stimulant such as mecholyl a rise in serum enzymes is expected. In a patient with a severely fibrosed pancreas this anticipated rise may not occur

Treatment of chronic pancreatitis is often difficult. Diabetes mellitus, if present, should be treated with diet and insulin in the usual way. In patients with steatorrhea, however, diabetes is frequently difficult to control because of the necessary reduction of the fat intake and because of the wide fluctuations observed from day to day in the insulin requirements of these patients due to variability in small bowel absorption and motility. There has been no problem in the patient presented because of the relatively mild diabetes he shows and his prompt response to fat restriction. To those patients who do not respond well with a decrease in fat consumption pancreatic ferments should be given. Fresh raw pancreas has been prescribed on occasion.16 Bargen and his associates administered pancreatic juice obtained from dogs and treated with trichloracetic acid to 2 patients with relief of steatorrhea and gain in weight. 17 A potent commercial enteric-coated pancreatic preparation. given in large doses, is the only substance of this type that can be readily obtained and prescribed by the average practicing physician. Dosage up to 25 grams daily has been administered with benefit.

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Figure 1.-A-P and lateral views of the abdomen demonstrating diffuse calcification throughout the entire pancreas.

Hemorrhage Into An Adenoma Of The Thyroid

A CASE REPORT

John H. Wootters, M. D., F.A.C.S. John K. Webb, M. D. Dept. of Surgery, Jefferson Davis Hospital Houston, Texas

It is well known that hemorrhage into adenomas of the thyroid is quite common. One pathologist has said that it is seen in practically every one. However, enough hemorrhage to require immediate surgical intervention is very rare.

Elsgerg,2 in 1910, reported a case of hemorrhage into a thyroid cyst that recovered following emergency surgery. Von Burg3 reported 12 cases of hemorrhage seen at the Zarick Surgical Clinic over a period of twenty years, but none were severe enough to warrant surgery. Von Ziemacki4 reported the case of a 65 year old woman who had a hemorrhage into the thyroid gland that broke through the fascial planes of the neck and dissected down to the umbilicua. The patient recovered without surgery. Plummer5 pointed out that hemorrhage into the thyroid gland even in small amounts, frequently caused pain in this region.

McGregor and Cornett⁶ reported the case of a 68 year old woman who had several attacks of minor hemorrhage into the thyroid gland. Then followed a massive hemorrhage and the patient expired during surgery.

In 1931, Clute7 reported on the common occurrence of hemorrhage into adenomas of the thyroid. He stated in his report that up to that time no patients had been seen at the Lahey Clinic where a hemorrhage into the thyroid was severe enough to endanger life.

We think the following case is worthy of inclusion in the literature because of the infrequent occurence of acute hemorrhage into the thyroid gland. Also because of the necessity of prompt diagnosis and treatment of this surgical emergency.

A 35 year old woman was seen in the Medical Clinic of Jefferson Davis Hospital on Feb. 11, 1947. At this time the patient complained of a swelling in the neck which had been present for three years. She was well nourished and appeared to be in good physical condition. Physical examination was completely negative except for a diffusely enlarged, freely movable, soft, thyroid gland with no signs or symptoms of hyperthyroidism. A diagnosis of multiple colloid adenomatous goiter was made and the patient referred for a basal metabolism test, which showed a rate of 3.5 on February 19, 1947. The patient was given Lugol's solution, ten drops three times daily, and advised to return in one mouth.

On March 27, 1947, the patient came in to the hospital emergency room complaining of chills, fever.

(Dr. Webb is a member of The Greenville County Medical Society.) and aching all over. She stated that she had begun to feel badly twenty-four hours before. Physical examination at this time revealed an anxiously ill patient with dyspnea and fever. Her body was hot and moist, the head was negative. The thyroid was enlarged. The chest showed equal expansion and normal fremitus but there was slight dullness with rales in the base of the right lung. The abdomen, pelvis, rectum, and extremities were negative. Reflexes were physiological. Blood pressure 130–80.

Laboratory findings; W.B.C. 11,500 with polys. 86%; lymphs 12%; monos. 2%. R.B.C. 4,150,000 with 84.4% hgb. Urine negative.

Roentgenographic examination of the chest showed an area of pneumonitis or atelectasis in the lower right lobe of the lung. A diagnosis of pneumonia was made and treatment with chemotherapy was instituted along with parenteral fluids, sedation, and oxygen.

Four hours after admission to the hospital the patient became more dyspneic and was struggling for air. She was then seen by the otoparyngologist who advised bronchoscopy. This was done but with no relief of dyspnea. The bronchoscope was inserted with difficulty due to a collapse of the trachea. No foreign bodies were discovered but there was a quantity of thick yellow mucous and the mucosa of the trachea was acutely inflamed. In view of the complete collapse of the trachea it was thought best not to do a tracheotomy. With the aspiration of the mucous and the institution of straight oxygen, the patient seemed to improve for a short time.

A few hours after bronchoscopy, the patient appeared to be almost in extremis. At this time it was noted that the thyroid gland was larger and more firm than formerly. A diagnosis of hemorrhage into a thyroid adenoma was made and it was decided to take the patient to surgery.

At the time of operation, twelve hours after admission, the patient was moribund and no anesthetic was necessary. On opening the neck, a large adenoma was seen and removed. The condition of the patient continued critical and in view of the long compression of the trachea, a tracheotomy was done. The lobes of the thyroid appeared to be normal and were not disturbed. The adenoma had arisen from the isthmus of the thyroid, was partially sub-sternal, and somewhat pedunculated.

The immediate post-operative condition of the patient was poor and the cyanosis and dyspnea continued in spite of a large tracheotomy tube and the administration of oxygen. After forty eight hours the patient improved rapidly and was able to be out of bed on the third post-operative day. Recovery was uneventful and the patient was discharged on the sixteenth day after surgery. Subsequent follow up showed the patient to be entirely well.

Pathological section of the tissue removed at surgery revealed a thyroid adenoma with hemorrhage into it.

Summary:

Hemorrhage into the thyroid gland severe enough to require immediate surgery is seldom seen.

Acute hemorrhage into the thyroid gland does endanger life because of pressure on the trachea. This pressure must be relieved either by tracheotomy or surgery of the gland itself.

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New Research Discoveries*

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Secretary, Therapeutic Trials Committee, Council on
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Association
Chicago, Ill.

I am deeply appreciative of the honor you have done me by asking me to say a few words to you on this occasion. During the past year or so, a number of medical organizations, including the American Medical Association, have celebrated their centennials. On such occasions, it is customary to look back and review the progress which has been made in the century just past. This, however, is not a very fruitful occupation unless one uses the information so obtained to predict the probable future course of events and to adapt one's course to direct such future actions into the most profitable channels.

In discussing a subject such as "New Research Discoveries," one cannot expect to do more than touch on some of the more significant advances, and, to make such a subject intelligible, some attention should be paid to the methods employed by scientists in discovering new facts and in developing new theories. Such a discussion reveals that the scientist, as an individual, like scientists collectively, commences a new project by first looking backward. However, he would never make a new discovery if he contented himself with merely a survey of progress made in the

past century. I can make this statement positively because medicine went through a period wherein its leaders contented themselves with a contemplation of the past and did not bother to apply the lessons so learned to the making of new discoveries. From the time of Galen until the Renaissance, no real progress was made in medicine. The writings of Greek, Roman, and Arabic physicians were accepted as gospel, and medical research was unknown. Then, a few original thinkers appeared, and contributions of a substantial nature began to be made. As more and more men became imbued with the spirit of scientific inquiry, the discoveries multiplied in geometrical proportions. During the past century, the period over which your own State Medical Association has existed, tremendous strides have been made in scientific medicine. In fact, so great has been the progress in the past 100 years that enormous volumes are necessary to record the significant facts which have been established by medical research.

Today, I would like to mention a few of the more recent discoveries which I believe will be of significance in the practice of medicine. In doing this, I am taking the chance of all prophets, that I shall be proved wrong. I trust, however, that my prognostications will be somewhat more accurate than those of certain well-known radio commentators.

All of you are familiar with the fact that the

^oGiven before The Woman's Auxiliary to The South Carolina Medical Association in Charleston, S. C. on May 13th, 1948.

products of atomic disintegration have opened new vistas to the medical scientist. One of the most practical and important peacetime uses of the knowledge gained through the development of the atomic bomb is the production of radioactive elements for use in medicine. It should be remembered that long before the development of atomic science as we know it today, radioactive substances have been used in the diagnosis and treatment of disease. Radium and some of its disintegration products, chiefly radon, have been used in medicine for more than thirty years, With the development of the cyclotron, small quantities of artificially radioactive elements became available to medical scientists. Two of these, radioactive iodine and radioactive phosphorus, were used to treat disease before the war. The atomic pile has now made available substantial quantities of many of the radioactive elements formerly produced in minute quantities by the cyclotron and, in addition, has produced a large number of new radioactive elements,

There are two principal uses for these radioactive elements, or isotopes, as they are usually called. Because these elements give off particles in the form of rays, extremely small quantities can be detected and measured by special instruments. The emission of these rays by radioactive isotopes permits one to photograph the location of the element, Furthermore, one can introduce into the body a chemical or drug containing one or more of these isotopes, and because the drug is "tagged" or "labeled" by this radioactive element, its course in the body can be followed, and any changes to which the drug or chemical is subjected can be determined, whereas ordinary chemical methods might not differentiate between the drug and other body chemicals. Such investigations with radioactive isotopes are called "tracer" studies, and through them we are learning many fundamental facts regarding bodily processes, drug action, and the effects of disease on the body chemistry. The radioactive isotopes have become additional tools in the hands of the medical investigator.

Like all tools, they must be used properly and intelligently, and they have very definite limitations. Not all problems can be solved by the use of radioactive elements, and incalculable harm may be done by misapplication or unskilled use of these tools. The Atomic Energy Commission is taking extraordinary precautions to see that only qualified experts obtain these tools. This is necessary for their own protection as well as for the protection of the public, since radioactivity in any form is daugerous.

The second use for radioactive isotypes in medicine is the treatment of disease. Since these elements give off radiations similar to x-rays and radium, the effects produced on the body cells are almost identical with those produced by these well-known therapeutic agents. However, by the proper selection of elements, selective irradiation of specific tissues can be achieved. When cancer, for instance, is treated with x-rays, it

is seldom possible to apply these rays just to the cancerous tissue. Inevitably, normal tissue lies in the path of the x-rays, and damage to normal bodily structures can occur. However, if the substance giving off these rays can be concentrated in the organ affected by the cancer, the harmful effects on normal tissue will be greatly minimized.

Radioactive iodine has been used to treat certain types of goiter. The thyroid gland picks up circulating iodine and concentrates it. Therefore, if some of the iodine taken into the body is made radioactive, it will quickly be picked up by the thyroid gland, and most of the rays given off by the radioactive iodine will affect only the goiter.

Leukemia, a disease of the white blood cells, which can be considered a "cancer" of these cells has been treated with radioactive phosphorus which circulates in the blood and may be deposited in bone, one of the sites of formation of white blood cells. Unfortimately, radioactive phosphorus is not a cure for leukemia, but some patients are made more comfortable and their life may be prolonged by this treatment.

Similarly, radioactive phosphorus has been used successfully in the treatment of polycythemia vera, a disease in which there is an excessive production of red blood cells. These cells and the cells from which they are formed in the bone marrow, appear to be particularly sensitive to the radiations given off by radioactive phosphorus.

Other elements such as gold, sodium, and iron have been made in the radioactive state, and their therapeutic properties are being explored. We shall undoubtedly hear more of these in the near future. A word of caution, however; one should not expect miracles from the applications of atomic energy to medicine. The effects and limitations of the radiations produced by these products have been known long before the development of the atomic bomb. The ultimate effects produced by these elements can differ little from those produced by x-rays or radium. They do, however, provide a new method of applying the radiations and, thus, can be considered a refinement of already well-known treatment methods. Do not be misled by over enthusiastic newspaper reporting regarding the possibilities of these substances in medicine.

Now, let us turn to some other medical problems, less exciting perhaps, but nonetheless significant. Not so long ago, the southern part of the United States, including your own beautiful state of South Carolina, had a fairly serious malaria problem. Perhaps some of you have been victims of the ubiquitous plasmodium and have had to take quinine at one time or another. All of you, I am sure, know how unpleasant and even dangerous a severe attack of malaria can be. Thanks to the efforts of your Public Health Officials and to your Sanitary Engineers, malaria is no

longer common in this country, and in fact, it is almost totally wiped out as an endemic disease in the South.

This state of affairs is, unfortunately, not true for vast areas of the world. Malaria was one of the factors responsible for the defeat of the Japanese land forces in the South Pacific. On the other hand, the development of effective antimalarial agents by scientists in this country was one of the major contributions to victory of our forces.

Before the war, there was available two antimalarial drugs: quinine and atabrine. Both are effective in suppressing certain forms of malaria, but neither can be relied on to cure the disease. Furthermore, quinine supplies were cut off by the Japanese invasion of Southeast Asia, and atabrine was not thought to be a satisfactory substitute. I might remark that we now know that it is. Both drugs produce some unpleasant side effects; quinine can make you deaf, and atabrine can turn you yellow. Personally, I'd rather be yellow han deaf, but some of the soldiers and medical officers, early in the war, felt differently.

The Office of Scientific Research and Development instituted a gigantic testing program to find new and effective synthetic antimalarials. In four years, over 16,000 chemical compounds were tested in animals for their ability to prevent or cure malaria and for their possible toxic effects. Out of these 16,000 chemicals, three new ones having superiority to quinine and atabrine were found. Two of these, chloroquine and chloroquanide, are now available and another, pentaquine, may be made available; unfortunately, however, it is fairly toxic although extremely effective against some forms of malaria.

All of you are familiar with the development of penicillin and streptomycin, and I do not think I need discuss these today. However, you may be interested in the work going on leading to the development of new antibiotic drugs to treat infections which do not respond to penicillin or streptomycin.

Since the discovery of penicillin, more than fifty antibiotic agents produced by molds, fungi, bacteria, and even plants, have been studied. Many of these have been discarded because they offered no advantages over penicillin or streptomycin, or because they were toxic when given to animals in therapeutic amounts. At present, there are three antibiotics under intensive study which appear to have some promise.

Bacitracin, a substance produced by a bacteria originally isolated from a bone infection of a little girl named Margaret Tracy, and named in her honor, seems to attack the same organisms as are attacked by penicillin. It may be useful in those instances where an individual is allergic to penicillin. It appears to be relatively nontoxic and is now undergoing extensive clinical trial. Several pharmaceutical manufacturers

are developing methods of producing bacitracin on a large scale.

Chloromycetin, a substance derived from a soil fungus, has shown possibilities of being effective against the organisms causing typhus and Rocky Mountain spotted fever, and against some virus diseases such as psitticosis and encephalitis. Only experiments on infected eggs and a few mice have been reported, and much more work will have to be done before we can be certain that chloromycetin will be a new "miracle drug," Its importance lies in the fact that, heretofore, virus diseases have not responded to any antibiotic or other chemotherapeutic agent. Perhaps, we are on the threshold of discoveries which will enable us to treat effectively such diseases as infantile paralysis, encephalitis, rabies, and other virus infections. I predict that in a few years we shall have effective drugs for these diseases; whether one of those drugs will be ehloromycetin it is too early to say,

Very recently, another antibiotic substance derived from a bacteria which grows in the soil has been studied. This antibiotic was discovered almost simultaneously in this country and in England. In England, it has been called "aerosporin" and in this country "polymyxin." This antibiotic appears to be effective against a number of the organisms attacked by streptomycin and, in addition, may be effective against some that neither penicillin nor sereptomycin affect, such as the organism causing undulant fever.

Polymyxin has been tried in the treatment of undulant fever. Preliminary reports are encouraging, but because the disease is notorious for its chronicity, final evaluation of polymyxin therapy cannot be made at this time.

I have only mentioned three antibiotics which are currently receiving attention by medical investigators. These three seem to be the most promising of the many which have been discovered. However, there are literally thousands of microorganisms, many of which are capable of producing substances lethal to other bacteria. It seems possible that we shall continue to hear of new antibiotics with exciting properties, but it must be remembered that not every agent which kills bacteria in the test tube will do it in the body. Furthermore, the drug must be safe as well as effective. Determination of safety and effectiveness of any new agent is difficult and time-consuming, and hence, early optimistic reports may not be confirmed by later investigations.

In the time remaining at my disposal, I should like to tell you a little regarding some investigations on the treatment of cancer now proceeding under the auspices of the Therapeutic Trials Committee of the American Medical Association. This investigation is concerned with the relationship of hormones to cancer.

I shall not attempt to bore you with an array of technical facts but shall attempt to outline to you, in general terms, some of the curious observations which have been made and tell you of the method which the Therapeutic Trials Committee has adopted to obtain fundamental information on this subject. Although I shall deal only with one isolated problem in cancer research, it should serve as an example of the manner in which research is conducted and the principles which must be observed in advancing the frontiers of medical knowledge.

I believe that you all are familiar with what we mean by "hormones." However, I might refresh your memory by stating that these substances are chemicals formed in certain glands of the body, secreted into the blood stream and which produce their effects on a variety of tissues and organs. For instance, the islet cells of the pancreas secrete insulin which regulates the utilization of sugar in the body, the thyroid gland secretes thyroxine which regulates the speed with which we burn nutrients in the body to obtain energy it is the so-called regulator of metabolism. Many of the characteristics which differentiate the male and female, both anatomically and emotionally, are determined and regulated by hormones secreted by the pituitary and gonads. All hormones bring about their characteristic effects because of certain specific actions on particular cells within the body. It is not surprising. therefore, that some of these hormones have been found to exert a profound influence on the growth of certain types of cancer cells, for these, after all, arc body cells which have "gone wild" and are no longer held in bounds by the normal processes which restrain and direct cell growth.

Those hormones which have been found to have an action on certain types of tumor cells are those commonly called the "sex hormones" because they are secreted by the ovaries or testes, and because they are responsible for initiating and maintaining certain sex characteristics. The discovery that the sex hormones can alter the growth of cancer cells was made only ten years ago, although such an action was postulated nearly twenty-five years ago. The isolation and purification of hormones is a relatively recent accomplishment, and until the research worker had pure materials in adequate quantities with which to work, he could not pursue critical investigations on their actions.

In 1941, Dr. Huggins of the University of Chicago, showed that carcinoma of the prostate gland could be checked, and in some instances, be made to disappear for varying periods of time by removing the testes. It was apparent from his observations that in the absence of the male sex hormone, the cancer cells derived from the prostate gland could not grow, and, in fact, often could not maintain themselves. In other words, the male sex hormone was one factor responsible for the growth of these cancerous cells. We know that it is not the only factor, and probably, the male sex hormone has nothing to do with causing the cancer. It does, however, provide a proper stimulus

or environment for the growth and multiplication of these cells once they are present.

These observations of Huggins on the effects of castration on prostatic cancer, suggested to him another approach to the treatment of such tumors. When a young man is castrated or fails to develop functioning testes, he assumes many of the characteristics of the female. What, then, would happen if large doses of the female sex hormone were administered to men with prostatic cancer? This was tried, and, as you have probably guessed, the cancers stopped growing and often disappeared temporarily. The results were not always as dramatic as those seen after castration, but for the first time, a chemical substance had been shown to exert a beneficial action in cancer.

It was reasoned that if the female sex hormone, or estrogenic hormone, as it is known, could inhibit cancer in the male, perhaps the male hormone could inhibit cancer in the female. It was known that removal of the ovaries sometimes produced temporary beneficial effects in women with breast cancer. It was also known that administration of the male hormone to women often produced effects quite similar to those seen after castration. Therefore, testosterone, the male hormone, was tried in the treatment of breast cancer. The first trials were very disappointing, but two years ago, Dr. Frank E. Adair of New York, reported eleven cases of far advanced breast cancer whose disease had attacked the bones, which responded with dramatic pain relief and disappearance of some of the cancer tissue in the bones. Dr. Adair's success appeared to be due to the use of doses of testosterone about ten times greater than those of his predecessors.

Now, as a result of these observations, a theory regarding the effects of hormones in cancer was advanced; briefly stated, this theory was that the normal sex hormones provided a stimulus to the growth and maintenance of cancer cells originating in those body organs normally controlled by the sex glands. Administration of a sex hormone, not normally present, created an unfavorable environment for these cancer cells, they ceased to grow, and many of them died. This was a very nice theory until some English workers and a group at Massachusetts General Hospital, under the leadership of Dr. Ira T. Nathanson, knocked it into a cocked hat by showing that, in some instances, the *female* sex hormone would inhibit breast cancer in the female!

It was obvious that a much deeper search would have to be made into the relationship of hormones and cancer if an explanation of the observed facts was to be found. Furthermore, not all patients respond to hormone therapy, and in some, it seems to make the disease spread faster.

Great interest in this field of therapy had been aroused, and the manufacturers of these hormones were besieged with requests for donations of material to treat indigent cases. Finally, several of these manufacturers approached the Therapeutic Trials Committee with the request that a thorough investigation of the usefulness of these hormones in breast cancer be undertaken with a view to determining, if possible, how and why these effects are brought about.

To cut a long story short, the Committee agreed to institute such an investigation and appointed a subcommittee to plan and evaluate this work. Fourteen pharmaceutical manufacturers have agreed to furnish the needed hormones free of charge; the amount of material being donated is valued at nearly \$100,000.

Many competent men were already at work on various phases of this problem, and others were interested. The subcommittee has enlisted the aid of forty-nine, institutions in thirty-eight cities in this country and Canada in collaborating in this project. The subcommittee has established a basic pattern for the investigation, but each collaborating group is pursuing a study of a particular phase of the project in which he has an interest and for which he has facilities. Through the cooperation of the Army Institute of Pathology in Washington, the records and specimens obtained in this study will become a permanent collection, available to all medical investigators who may wish to see the original data

obtained by the participants in this project.

All of these investigations are being made with the cooperation of patients with advanced cancer of the breast. It is expected that by the end of this year, nearly 1000 persons will be under treatment with hormones, and the information gained by a careful study of these unfortunate individuals may eventually point the way to their salvation and to the salvation of others similarly afflicted.

The active institution and participation by the American Medical Association in major research projects is a relatively new venture. Heretofore, the Association has made grants of money to medical investigators and given encouragement to others. Now, however, the Association, through the Therapeutic Trials Committee, is actively initiating research projects, not only in cancer, but in many other fields.

I would like to tell you more about the various research activities of the American Medical Association, but time does not permit. I think, however, that the very brief sketch I have given you will indicate that, as it has during the past 101 years, the Association is ever seeking ways to bring better health and higher standards of medical care to the American people.

Plan To Attend

ALUMNI POST-GRADUATE SEMINAR

Charleston

Nov. 2, 3, 4.

The Journal of the South Carolina Medical Association

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OCTOBER, 1948

AN ORCHID

As members of our Association attain honors it is only appropriate that they be given full recognition.

In an advance copy of the program for the Section on Proctology, Southern Medical Association, we find the name of our former past-president, Dr. Thomas Brockman of Greenville, listed as chairman. The subject of his address will be "How May A Proctologist Best Serve His Patient and The Profession."

Congratulations, Dr. Brockman, and may many members of our Association be in the audience when you deliver your speech.

JOHN H. PORTER

When Dr. John H. Porter died recently, the medical profession of South Carolina lost one of her strongest supporters, and the Medical College one of her most loval friends.

A general practitioner in Andrews, Dr. Porter soon became interested in political affairs. For a number of years he served as a Representative from his county in the General Assembly, and for the past few years was Chairman of the Committee on Medical Affairs of the House. Legislation dealing with the medical affairs of the state was sent to his committee where he saw to it that careful study was made and strenuous effort was exerted to see that it was in line with the best thought of our Association. Dr. Porter was also, for many years, a member of the Board of Trustees of the Medical College and gave freely of his time and talents toward the promotion of its interests. At the time of his passing, Dr. Porter was the only member of the House of Representatives who was a physician.

His friends and colleagues mourn his passing and extend their deepest sympathies to his family.

PIEDMONT POSTGRADUATE ASSEMBLY

The annual Piedmont Postgraduate Assembly, held recently in Anderson, was a great success. With good speakers, a good variety of subjects for discussion, and over 135 in attendance, it proved to be even better than former gatherings. And far from the least important part of the meeting was the gracious hospitality of the physicians of Anderson.

The physicians of the Piedmont section of this state are due a great deal of credit for the time and effort which they have expended in making this annual affair so notable. Other sections of the state would do well to heed the example set by our colleagues in our northwestern counties and to promote similar institutes for their members.

THE EWING REPORT

Oscar Ewing, Federal Security Administrator, has presented his report to the President who in turn released it to the nation. It is to be regretted that Mr. Ewing did not confine his recommendations to those which were adopted at the National Health Assembly. Instead, he included such recommendations as met with his approval, and then added his personal recommendations. One of the latter was the advocacy of a federal health insurance plan for all the people. So far as we can see, there is only one reason for Mr. Ewing's premature presentation of his report. This is a political year and Mr. Truman wanted the report as ammunition in his campaign.

To those who have followed Mr. Ewing's speeches and actions, there is nothing new or startling in the report. It is a well prepared and readable document presenting the arguments of those who are in favor of a system of federal medical care for the people of this country. Every physician would do well to secure a copy of this report and to read it carefully if he is to participate intelligently in the debate which lies ahead.

THE TEN POINT PROGRAM

M. L. MEADORS, EXECUTIVE DIRECTOR AND COUNSEL

BRITISH HEALTH SERVICE APPRAISED

Britain's new Health Service, according to the story appearing in a recent issue of the London Daily Mail, "is menaced by the humbug."

Shades of Scrooge and Marley's Shade! The "humbug" used in the newspaper, however, seems to have a more specific meaning than the favorite expletive of the central character in Dickens' novel. The "Humbug," says the Daily Mail, "is the man or woman who needlessly wastes the overworked doctor's time and steals his eare and ministrations away from the sick and suffering."

According to the writer, Britain's 18,575 National Health Service doctors are dreading the winter after a July and August during which there has been more "siekness" than in any summer within memory. The writer continues, "It has already become obvious that the scheme's popularity is its worst enemy. The enthusiasm with which the public has received it now threatens to throw it into chaos.

"During the past week I have invited doctors—some who were originally "for" and some who were "against" the service—to give their judgment on it based on eight weeks' experience.

"And nearly all are agreed on this one main trouble—too many patients.

"Take for example, a young Essex doctor who has built up a successful private practice as a general practitioner.

"He owns a small house and in it has a well-equipped surgery with a waiting-room designed to accommodate 17 patients.

"At his morning session, which is supposed to last two hours, he now often has over 60 patients. Once he found 73 people waiting for attention.

"In a day he frequently deals with a total of about 120 callers at morning and evening surgeries—and has to find time in between to call on 25 or 30 patients who are too ill, or say they are too ill, to leave home.

"Another doctor with an even smaller waiting-room sometimes has a queue through his home and garden and out into the street."

Despite the new role as servants of the State, the physicians in England have not lost their professional interest. The writer in the Daily Mail reports that "The doctors' worry is not so much overwork. They are afraid that they are being rushed out of giving the careful attention which many of the eases deserve.

"Of the extra patients who are now flocking to the surgeries many are genuine enough. They have ailments which have long been neglected probably for financial reasons.

"But there are others with imaginary or trifling

complaints who previously have been deterred from visiting a doctor by the knowledge that it would eost them a few shillings.

"Worst menace of all are those with imaginary ailments who phone to the doctor demanding that he pay an immediate visit.

"Although the doctor may be almost convinced that a visit is unnecessary, he usually dares not risk refusing to go.

"One doctor showed me his visiting book for August, 1947, and August, 1948.

"The book for this August revealed, apart from a 100 per cent increase in visits, a far bigger percentage of cases crossed off after the first call."

The article continues, pointing out that in addition to the shortage of doctors developed by the great influx of patients, the demand for medicines has soared, with chemists reporting increase of between 75 and 100 per cent in prescriptions dispensed, resulting in a serious shortage of small bottles. There has been an increased demand for free spectacles and hearing aids. According to this writer, there is a belief on the part of some that there is a change in the old doctorpatient relationship. Now they say they are all too often regarded as eivil servants merely doling out a ration.

The writer, so far as his by-line indicates, is not a physician. He is a newspaper reporter or feature writer. It may reasonably be assumed that he reported the facts as he found them, impartially and without conscious prejudice.

SUPPORT OF AUXILIARY BY STATE SOCIETIES URGED

The following Resolution, proposed by a Delegate from the Oregon State Medical Society, was adopted by the House of Delegates of the American Medical Association at its recent annual meeting in Chicago.

In thus endorsing the principle of direct, active financial support of the Women's organization by constituent State Medical Societies, by appropriation of funds to defray their expenses, the national body followed, whether knowingly or not, a step which had already been taken by the South Carolina Medical Association. At the May meeting in Charleston, Council approved the payment of travel and other expenses of the President and certain other officials of the Woman's Auxiliary.

In other ways South Carolina has been in the vanguard of the thinking on the practical importance of the Woman's Auxiliary. It is hoped that all the state organizations will follow the suggestion contained in this Resolution.



The inactivity following surgery or disease, and often encountered in the aged, makes constipation a likely occurrence. Dehydration, too, frequently is a significant contributing factor.

When the "smoothage" of Metamucil is employed in the management of constipation, normal evacuation is permitted without irritation or undue pressure on sutures and incisions. Thus straining is minimized.

Metamucil promotes smooth, normal evacuation by furnishing a non-irritating water-retaining colloidal residue in the large bowel.

RESEARCH IN THE SERVICE OF MEDICINE

SEARLE

METAMUCIL® is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%), as a dispersing agent.

"Whereas, Our local state and national woman's auxiliaries have become an indispensable adjunct of organized medicine; and

"Whereas, The local state and national auxiliaries are especially effective as agencies for furthering the education of the public concerning the aims and accomplishments of scientific medicine; and

"Whereas, Their maximum effectiveness requires participation by the wife of every member and sufficient funds to enable them to earry on their essential activities; therefore be it

"RESOLVED, That each constituent state medical association be urged to budget sufficient funds to defray the cost of the activities of its auxiliary and to pay the annual dnes of the national auxiliary, thus making the wife of every member automatically a member of the state and national auxiliaries and eliminating the collection of state and national auxiliary dues from individual auxiliary members."

MRS. ADCOCK APPOINTED REGIONAL CHAIRMAN

Mrs. David F. Adcock of Columbia has been appointed Regional Chairman and a member of the Standing Committee on Legislation of the Woman's Auxiliary to the American Medical Association. The southern region which Mrs. Adcock will head in this important phase of the work of the national body consists of Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee and Texas.

The outstanding work led by Mrs. Adcock as President of the Woman's Auxiliary to the South Carolina Medical Association last year, was an achievement which will be remembered with pride by members of the Auxiliary and the Association alike. As Regional Chairman on Legislation for the national organization, her duties will be to keep posted and stimulate interest on legislative matters and to coordinate legislative activities among the states in her region.

THE DOCTOR AND PUBLIC HEALTH®

^oThe address of Leo F. Simpson, M. D., President of the Medical Society of the State of New York, Delivered before the Annual Conference of Health Officers and Nurses, Saratoga Springs, N. Y., July 21, 1948.

It was, I believe, H. G. Wells, the late English writer and historian, who made the pertinent remark that education is a race against catastrophe. It seems to me especially significant that we are gathered here at this time to evaluate our experience in the field of health and medicine while at the same time it would seem that the world is tottering on the brink of a terrible abyss opened up by the advent of the atomic age.

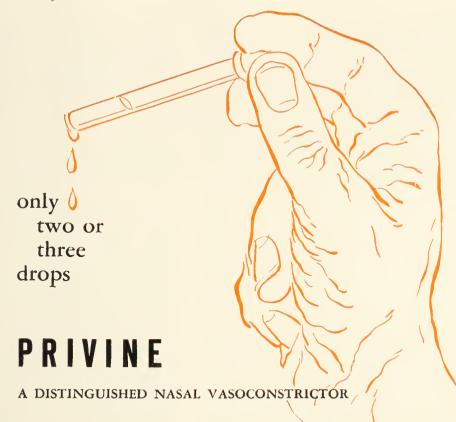
It would perhaps be more accurate to state that the threat of disaster comes not from the enormous strides taken by science, for these steps could lead to a peaceful world—a world in which man could realize his potentialities more than ever before. No, the fault is in the failure of the human mind to evolve proper methods of dealing with the new tools which scientifie research has made available.

In a sense, we who devote ourselves to the health and welfare of mankind, individually as well as eollectively, stand as a thin line of shock troops against the destructive forces which are threatening to nullify all the advances of science which have enabled man to rise above the savagery of his primordial days to the comparatively advanced civilization in which we live today. But we are a thin line. The strength of the opposing forces, now still but a threat, is so enormous that, should it materialize, the accumulated work of centuries of progress will be obliterated in a moment, Within the experience of most of us, two violent wars have occurred and each of these has had its retrogressive effect upon our general well-being. It must be plain to anyone who thinks about the situation that the general level of health eannot but suffer a decline, when the very flower of our race is periodically sacrificed to the gods of war.

Thus, it appears to me that we are in a position now where not only must we work to our utmost, to rectify the blunders of the past, but we must strive in every way to keep the frail plant of human existence from becoming uprooted by the gathering storm.

Much has been said and written of the divergence between the aims of the individual doctor and the advocates of public health, but I am not one who believes that they stand in opposition to each other. I look upon the physician and the public health officer as mutually supporting each other in their efforts to enable man to live more successfully in his environment. That one may be said to coneern himself more with the environment, and the other with the individual, does not alter the close relationship of the two. Even this is not an accurate statement of their mutual dependence because of the frequent overlapping of the two fields. That there should be opposition between the two is a mistake. Disagreements that have arisen in the past have been largely due to the failure of either one or the other to realize that they have a common objective. In peace time we should be as brothers in our efforts. In time of war we mareh shoulder to shoulder.

The doctor, without doubt, is an individualist; the public health officer thinks in terms of entire populations. But we must not lose sight of the fact that the doctor is equally concerned with the welfare and well-being of the community at large. Whether the viewpoint be that from above or below, the aim cannot be different. It is perhaps difficult for those who have been trained to accept the larger view, to understand the doctor's emphasis on his personal relationship with his patient. It is this relationship which the



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doctor traditionally guards and which has made him hostile to schemes for providing medical care which would break down this relationship.

No one recognized more than the doctor the right of anyone, regardless of race, creed, color or economic circumstance, to good health. No one is more aware than he of the need for a wider and better distribution of medical care. But he does insist that medicine is a profession and that in the personal administration of his professional skill, in the treatment of the individual *as* an individual, with regard to all the special circumstances which his individual case arouses, the sanctity of this personal relationship must be maintained.

It is discouraging to the doctor to see himself pictured as an obstacle to progress, because of his insistence upon the maintenance of the high quality of medical care. No matter how imperative may be the expansion of the quantity of medical care, we can gain nothing in our effort to increase its availability if the quality is reduced.

We in the United States pride ourselves on having the highest standards of medical care and public health in the world. Let us guard against a deterioration brought about by excessive eagerness to meet a problem that has no simple solution.

At the recent National Health Assembly in Washington, there was general agreement that the principle of contributory health insurance should be the basic method of financing medical care for the large majority of the American people in order to remove the burden of unpredictable sickness costs, abolish the economic barrier to adequate medical services and avoid the indignities of a "means test." This principle was approved by all the participants at the conference—even by those who are known to entertain divergent views. As a principle, it stands as a laudable statement. I suspect, however, that it will be subject to various interpretations by persons of different views and that the term "contributory health insurance" will require a clearer definition before the principle can be translated into action.

If the future shows that "contributory" health insurance is meant to mean "compulsory" sickness insurance, with its regimentation of the physician and the removal of the right of the patient to the free choice of his own physician, you can expect the medical profession to throw its weight against it. If, on the other hand, there is a sincere attempt to set up a program of insurance which will enable the patient to provide for the costs of medical care in a democratic way, you will find that the medical profession will not only support it, but will lend its earnest cooperation to widen the benefits of such insurance even well beyond its present limits.

It is well known that doctors have shown their willingness to cooperate in voluntary group health pre-payment plans providing comprehensive service to their members. In recent years this cooperation has found a surprising amount of acceptance on the part of the public. Here in New York State, where there are six pre-payment plans that have met the approval of the Medical Society of the State of New York, membership in these plans has risen phenomenally within the last few years and now stands at 1,300,000 persons.

I mentioned earlier that the doctor occupies himself with the problems of the individual while the public health officer is concerned with community environment. I tried to emphasize that the cleavage between the two is not, and should not be, sharp. Naturally the doctor cannot regard his patient entirely as an isolated phenomenon; neither can the public health officer deal entirely with abstract statistics and concern himself with communicable diseases, sanitation and hygiene without regard to the individual. Nevertheless, the best interests of the patient as an individual, and as a member of his community, will be best served by a steadfast devotion by all of us to those phases of health and medicine in which we are each best trained to function.

The very first section of the Principles of Ethics of the American Medical Association, it should be remembered, states:

"A profession has for its prime object the service it can render to humanity; reward or financial gain should be a subordinate consideration. The practice of medicine is a profession. In choosing this profession an individual assumes an obligation to conduct himself in accord with its ideals."

Those who are familiar with the Ten Point Health Program of the American Medical Association are well aware that it embodies provisions that are earefully planned to bring to the American public the maximum benefits of modern medicine at a cost they can afford to pay, and that it also provides for a full complement of public health services rendered by professionally competent health departments.

The pattern has thus been set for a wide area of joint effort on the part of the medical profession and the public health officials. There remains, of course, much to be done in singling out problems and combining the resources of both to overcome them. Undoubtedly there will still be room for considerable differences of opinion and a healthy scepticism on both sides. But the end result will be a closer approach to the fundamental solutions of the problems that beset our society's constant search for a higher standard of health.

There is one particular area for cooperation of which I might make special mention, and this is one which will engulf us if the threat of atomic warfare to which I referred in my opening remarks becomes a reality. All of us, I am sure, have given serious thought to the staggering health and medical problems that will follow in the wake of an atomic ex-

plosion. We doctors, and I know many of you, too, have recently started to prepare for such an eventuality. We are fully aware of the vast amount of coordinated effort which must go into the preparation for meeting an emergency on the scale of that which is likely to present itself should atomic disaster strike. We are resolved to take our proper place in the battle for survival and give of our utmost to the common cause.

There are, however, several disturbing elements in the atomic defense picture, and they are matters that I believe should be given careful consideration.

It is generally recognized that the explosion of a single atomic bomb in a metropolis of a nillion or more people may cause 300,000 casualties, and that a large number of these–possibly 100,000–will suffer from shock, hemorrhage and the effects of radio activity. They will be in need of immediate blood transfusions. It also is accepted that the present facilities for collecting, storing and transporting blood are insufficient to meet the demands of an emergency of such proportions. None of the metropolitan areas could, by themselves, supply more than a fraction of the need for whole blood for their own use should they be ravaged by an atomic bomb, even supposing that their existing supply miraculously escaped destruction.

Once we have agreed that an emergency situation is a possibility, it follows as a matter of course that some way must be found to collect, store and distribute the vast quantities of fresh whole blood that will be required. Under those circumstances, there appears to be no other way than to enlist the cooperation of those voluntary organizations best able to undertake the task.

An extraordinary problem must be met by an extraordinary solution. No large-scale emergency can ever be coped with by business-as-usual methods. Hiroshima was no optical illusion.

Yet, I would not be faithful to my trust as President of the Medical Society of the State of New York if I were to be silent regarding some serious difficulties which are connected with plans for wholesale blood collection, no matter how well-intentioned.

First, it seems to me that the doctor has an inescapable moral and legal responsibility to the patient for the safety of the blood given to him, whether in times of peace or in war. This is a responsibility that he cannot shirk or transfer to others, and neither is it proper that others assume it. The doctor's whole concept of his role in society is open to question if he blindly surrenders his plain duty under the presure of circumstance. I do not doubt that new situations call for new remedies, but I do not believe that fundamental principles ever change.

Consequently, I must make myself clear that the medical profession always will be compelled to insist that the creation of large resevoirs of blood be undertaken under the strictest kind of medical supervision.

and under conditions best suited to safeguard the health of everyone involved. This has been the principle that has too easily been waived by well-meaning persons, even in times of peace in their eagerness to create blood banks as a community service. Here in New York State, the medical profession has been made to appear reactionary and self-interested, simply because it has sought to prevent a widespread deterioration of the supply of whole blood due to a decline in standards. This is unfair. There is, no doubt, strong popular pressure for the establishment of blood banks on a large seale, and it is fitting that, wherever proper methods for collection and distribution can be set up. such banks should be established. But the insistence upon adequate safeguards, and blind opposition to progress are two different things. A more ready willingness on the part of those who advocate community blood banks to understand the medical point of view, would do much to clear up misunderstanding.

The second point I wish to raise goes behind the surface and deals with the philosophy involved. The proposal to operate emergency blood banks in times of disaster can scarcely be questioned. No doctor would withhold from anyone in such a circumstance, any more than he would in a time of peace, every resource at his command and all his personal ability to save the life of any stricken person. But, the doctor, together with a great many others, cannot overlook the fact that the pattern of the past has too often demonstrated that under the guise of an "emergency", some of our most fundamental principles have been modified—ostensibly on a temporary basis—but, as we all know, they have remained firmly implanted long after the "emergency" has passed. The word "emergency" is elastic. In a sense, we are living under emergency conditions all the time and perhaps never more than now.

It seems to many of us that the tiny hole in the dike has already been widened to such an extent that we are near to being flooded by new un-American principles that first seeped in as temporary stop-gaps, Each further concession extends the breach and with each we move more and more away from the basic principles under which our nation was founded.

Good health can never be a controversial issue. We are not attempting to make it such. Yet we in the medical profession must express our concern over the apparent readiness of some persons to drift toward an economy of collectivism without heeding the manifold danger signs along the way.

I repeat. The presence of a national emergency will lead the doctor to modify his views on many things. But for several reasons he will do so reluctantly and, firmly convinced, that should the emergency happily fail to materialize, the normal pattern of operations should prevail.

Let use assure you that the medical profession will not be found wanting in time of need. We have a proud tradition behind us to serve as an example, and we are ready to demonstrate that we aspire to be even more worthy of the trust placed in our hands. We believe that much can be accomplished by a united approach to the many problems that confront us, and we stand ready to contribute our best efforts toward the betterment of our fellow men.

It has not been my intention, by dwelling upon the possible horrors of an atomic disaster, to act the part of a Cassandra and paint the future with an unnecessarily dark brush. I have simply tried to be realistic in the face of unpredictable eventualities. It would be foolhardy to be excessively optimistic in the

light of current events.

While the immediate future is far less bright than we would like, let us not give way to despair but rather look upon it as a challenge to bring out the best that we have to give to it. As an inspiration, I like to think of the words of Alfred North Whitehead, who, in summing up the position of science in the modern world, said:

"We must expect that the future will disclose dangers. It is the *business* of the future to be dangerous; and it is among the merits of science that it equips the future for its duties."

PUBLIC HEALTH NEWS

DOCTOR CHAPMAN EMPLOYED WITH MATERNAL AND CHILD HEALTH DIVISION, SOUTH CAROLINA STATE BOARD OF HEALTH

Doctor William H. Chapman of Bishopville, S. C., is now employed with the Division of Maternal and Child Health of the State Board of Health.

Doctor Chapman's work will be principally educational, with emphasis on the program of child growth and development and better family life. He will be available as a speaker to local medical groups; he will advise with the local health department staff in helping to bring about a better understanding and more consideration for the emotional side of the mother and baby in maternal and child health clinics; and he will participate in institutes for nurses (public health, institutional, and private duty), teachers, welfare workers, parent-teachers associations, and other groups who deal with child life.

Doctor Chapman has a background rich in both education and experience which will provide a wealth of knowledge for this work. He studied at Furman University, Greenville, S. C., and Mt. Vernon College. Baltimore, Maryland. He was graduated from the University of Maryland School of Medicine, and served his internship at Women's Hospital, Baltimore, Maryland, after which he was Resident at Petersburg Hospital, Petersburg, Virginia, for two years. For several years he was a Medical Officer with the Veterans' Administration Hospitals, his work there being chiefly in the field of psychiatry. In recent years Doctor Chapman served as assistant to Doctor Hugh Wyman, with the Richland-Columbia Venereal Clinic.

In June 1947, he completed a year of post graduate work in Psychiatry at the Child Guidance Home. Cincinnati, and the University of Cincinnati College of Medicine with Doctors Milton Rosenbaum and Krug Brady. Since that time he has engaged in private practice, limited to psychiatry.

DR. HEISE ACCEPTS POSITION WITH RED CROSS

Dr. E. Alex Heise, former director of the Sumter City-County Health Department, who recently resigned to become southeastern area medical director for the National Red Cross with headquarters in Atlanta, Ga.

Dr. Heise received his early education in the Columbia City schools and at Duke University. In 1933 he received his A. B. degree from the University of South Carolina. He graduated from the South Carolina Medical College in 1939. Following a year's internship at

the Columbia Hospital he entered the University of N. C., and graduated in June, 1941 with the degree of Master of Public Health. He became director of the Sumter City-County Health Department on July 1, 1941.

TWO FALSE RUMORS

False rumors breed uncertainty and discontent. Definitely false is the rumor which has recently gotten out that syphilis is about to be treated now with 2 doses of penicillin, and that the Rapid Treatment Center, in Florence, S. C., is about to fold up.

There is nothing in the files of the Venereal Disease Division to indicate any change in the near future from the present treatment of syphilis. True, we hope that some day the treatment of syphilis may resolve itself even to one dose, but until Medical literature presents evidence of a preparation which is effective in fewer doses than those at present given, there will be no change in the policy of the Venereal Disease Division.

As to the R.T.C., for the past two years we have been struggling to acquire this property and to have the title vested in the name of the State Board of Health. We have only recently succeeded in attaining this goal. We certainly do not intend now that we have acquired the buildings to close them up and stop the program. We, therefore, do not contemplate any closure of the R.T.C., at the present time or in the near future. —R. W. Ball, M.D., Director, Division of Venereal Disease Control.

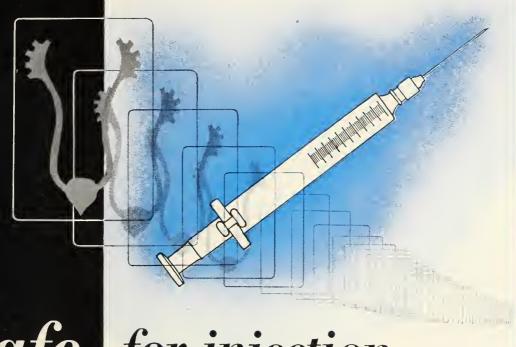
BIRTHS

Dr. and Mrs. Hervey W. Mead announce the birth of a son, Stanley Winthrop, August 16, in Columbia.

Dr. and Mrs. David Reese of Greenville, are being congratulated upon the birth of a daughter on August 7

Dr. and Mrs. Robert S. Piper of Florence are being congratulated upon the birth of a daughter.

Announcement has been received of the birth of a daughter on September 22, to Dr. and Mrs. E. D. Guyton of Florence.



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DEATHS

IAMES NILES NESBITT

Dr. James Niles Nesbitt, 82, died at his home in Gaffney on August 29, after a long illness. A graduate of the University of Tennessee Medical College, Dr. Nesbitt had practiced medicine in Gaffney almost fifty years. He was an honorary member of the South Carolina Medical Association.
He is survived by one son and four daughters.

MARION RUDOLPH MOBLEY, JR.

Dr. Marion R. Mobley, Jr., died at a hospital in Florence on September 12 after an extended illness. Only twenty-six years of age at his death, Dr. Mobley received his education in the schools of Florence, Davidson College and Vanderbilt Medical College. He scrycd his internship at Pittsburgh University Center and was a resident physician at Massachusetts Eye and Ear Infirmary, Boston. For the past year, when able to work, he had been associated with his tather at the Mobley-Stokes Clinic. He is survived by his widow and one daughter.

JOHN HENNING PORTER

Dr. John H. Porter, practicing physician of Andrews for more than twenty-five years, died at a hospital in Florence, September 17, after an illness of several

weeks. He was 55 years old.

A native of Georgetown County he had been a member of the House of Representatives from that

county for the past eighteen years. Survivors include his widow, a stepson and two sisters.

AMBROSE MILLER WYLIE

Dr. Ambrose Miller Wylie, 73, died at his home in Chester, September 21, after an illness of almost a year. A native of Chester County, Dr. Wylie received his education in the schools of Chester County, Erskine College, and was graduated from the Medical College of the State of South Carolina in 1903. Hc had practiced medicine in Chester for more than fortyfour years and was an honorary member of the South

Carolina Medical Association.

He is survived by his widow, three sons and two daughters.

THE ATLANTA GRADUATE MEDICAL ASSEMBLY

announces its 1949 meeting

January 24, 25, 26

Among the speakers will be:

Dr. George C. Burch

Dr. Konrad E. Bloch

Dr. Henry L. Bockus

Dr. George Crile

Dr. Lester R. Dragstedt

Dr. Sidney Farber

Dr. E. C. Hamblen

Dr. Charles E. Irwin

Dr. Walter Kempner

Dr. Oswald S. Lowsley

Dr. W. F. Mengert

Dr. William C. Menninger

Dr. Rufus F. Payne

Dr. R. H. Smithwick

Dr. Everitt D. Sugarbaker

Dr. O. H. Wangensteen

Make your arrangements now to attend.

WOMAN'S AUXILIARY SOUTH CAROLINA MEDICAL ASSOCIATION

President: Mrs. P. M. Temples

Publicity Secretary: Mrs. William H. Folk

The Woman's Auxiliary to the South Carolina Medical Association shall miss our beloved member. Mrs. W. L. Pressly, Due West, South Carolina.

Dr. Pressly is on our Advisory Council and members of the Woman's Auxiliary to the South Carolina Medieal Association wish to express our love and sympathy to you in your sorrow.

Mrs. Pressly was a member of the Woman's Auxiliary to the Third Medical District.

Members of the Woman's Auxiliary to the Greenville County Medical Society opened their fall work with a luncheon meeting September 6, 1948 at the Poinsett Hotel.
Dr. R. M. Pollitzer and Dr. T. G. Goldsmith, physi-

cians on their Advisory Committee, were present to

discuss auxiliary plans.

Mrs. Powell M. Temples, President, Woman's Auxiliary to the South Carolina Medical Association, Spartanburg, South Carolina, was guest speaker. Mrs.

Temples spoke on phases of auxiliary work pointing out that "Increased Membership" and "Nurse Recruitment" should be stressed this year.

The Greenville Auxiliary presented Mrs. Temples with a beautiful French Antique China Celery Dish.

Mrs. William II. Folk, State Publicity Secretary,

accompanied Mrs. Temples to the luncheon.
Mrs. Mordecai Nachman, Mrs. W. H. Lyday, and Mrs. I. E. Crosland were in charge of the luncheon.

Mrs. Lyday conducted several contests and prizes were donated by Greenville Merchants.

Each place was marked with place cards bearing the medical auxiliary emblem, and the Winchester-Ritch Surgical Company, Greensboro, N. C. gave each a finger nail file. Mrs. Everett B. Poole made the unique place cards.

Mrs. H. M. Whitworth, President of the Greenville Auxiliary, served as toastmistress. Mrs. Whitworth also presided at a short business session. The Greenville

Auxiliary has a membership of sixty.

NEWS ITEMS

Dr. Walter E. Bryant, who has been associated with Dr. O. A. Alexander in Darlington, has joined the staff of the Johnson Memorial Hospital in Hemingway.

Dr. William Atmar Smith of Charleston delivered a talk at the Southern Tuberculosis conference in Savannah, September 30-October 2.

Dr. Homer S. Parnell is now associated with Drs. Charles N. Wyatt and Horaec M. Whitworth and will limit his practice to surgery.

Dr. James B. Galloway of Bishopville was elected President of the Seventh District Medical Association at a recent meeting. Other officers elected were: Vice Presidents; Dr. Sedgwick Simons, Bishopville; Dr. A. C. Bozard, Manning; Dr. Michael Holmes, Kingstree; and Dr. Norman Eaddy, Sumter, Dr. W. E. Wlutley, Andrews, and Dr. Carl B. Epps, Sumter, were elected secretary and treasurer.

Dr. E. Alex Heise, formerly health officer of Sumter County, is now medical director of the Southeastern area of the American Red Cross offices in Atlanta.

Dr. Robert S. Piper has opened offices in Florence for the practice of general medicine.

Dr. William H. Mathis, Jr., is now associated with Drs. Will S. Judy and Samuel H. Fisher in Greenville.

Dr. John M. Rhame has opened an office at Sumter for the practice of medicine and is the newest doctor to locate there.

Dr. Rhame is a native of Camden but has made his home here for the past eight years with Mr. and Mrs. E. Murr Hall, his uncle and aunt. He is a graduate of the Citadel and the Medical College of the State of South Carolina. His interneship was taken at Roper Hospital, Charleston. He served as captain in the medical corps for two years during the war.

Dr. Cliff Ratcliff, formerly of Anson County, N. C., has opened offices at 3911 Ensor Avenue in Eau Claire, as a general practitioner.

Doctor Ratcliff received his pre-medical training at Duke University in Durham, N. C. and his medical degree at the University of Maryland. His internships were served in Baltimore at the University Hospital and St. Agnes Hospital, and for two years he was in the Army Medical Corps at Staten Island Area Station Hospital, New York.

He and his wife and son are residing at 3903 Ensor Avenue, in Eau Claire.

SCHEDULE OF CANCER SEMINAR

The Cancer Seminar of the Southeastern States will be held on November 8, 9, and 10, 1948, at the Tampa Terrace Hotel, Tampa, Florida. The Seminar is under the direction of the Tumor Clinic, Tampa Municipal Hospital, Tampa, Florida, and is sponsored by the American Cancer Society, Florida Division, and the Florida State Board of Health.

The Cancer Seminar will consist of morning and afternoon sessions, presenting in panel discussion Carcinoma of the Breast, Carcinoma of the Lung, Carcinoma of the Uterus, Carcinoma of the Ovary, Carcinoma of the Stomach, and Lymphoblastoma-Leukemia.



There is a way to lighten the burden of nutritional privation in older individuals. The method is the routine prescription of GERILAC to supplement the diet of your elderly patients. This will be particularly appreciated by those with whom material want goes "hand in glove" with advanced age.

At a cost of only 19¢ a day, Gerilae is all the more economical because it does not require mixing with milk. One reliquefied pint of Gerilae provides ¼ of the proteins, a full allowance of each of the necessary vitamins* and minerals, and 300 calories in two 8-ounce glasses of tasty drink. With this fortified formula of spray dried whole milk and skim milk, Gerilac provides a specifically designed economical preparation for the aged.

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Each symposium will be discussed by a surgeon or internist, a pathologist, and a roentgenologist, who will handle the various phases of diagnosis, pathology, and treatment. At the end of each panel discussion, thirty minutes will be allowed for questions submitted by the audience.

This Seminar is conducted for the doctors of the Southeastern States and primarily intended for the benefit of physicians in the general practice of medicine; however, specialists in any field of medicine are

urged to attend.

Requests for hotel accommodations should be sent to Mr. A. K. Dickinson, c/o Tampa Chamber of Commerce, Tampa, Florida, stating in your communication that you are attending the Cancer Seminar.

PROGRAM

Eleventh Annual Symposium Duke University School of Medicine and Duke Hospital Durham, North Carolina

November 4, 5, and 6, 1948

Thursday, November 4, 1948 2:00 P. M.

- Dr. Harry Gold, New York, New York Newer Trends in the Management of Congestive Failure
- 2. Dr. Carl V. Moore, St. Louis, Missouri Recent Advances in the Treatment of Anemia
- 3. Dr. Harry L. Rogers, Philadelphia, Pennsylvania Recent Therapeutic Trends in Allergic Diseases

6:00 P. M.

Dinner at Hope Valley Country Club

8:00 P. M.

 Dr. C. P. Rhoads, New York, New York Recent Advances in the Treatment of Malignant Neoplastic Disease 2. Dr. William L. Bradford, Rochester, New York Recent Developments in the Prevention and Treatment of Certain Communicable Diseases

Friday, November 5, 1948

10:00 A. M.

- 1. Dr. Wallace E. Herrell, Rochester, Minnesota The Present Status of Antibiotic Therapy
- 2. Dr. Stewart H. Clifford, Boston, Massachusetts The Prevention of Neonatal Mortailty

2:00 P. M.

- 1. Dr. Carl F. Schmidt, Philadelphia, Pennsylvania Newer Trends and Methods in the Development of Therapeutic Agents
- 2. Dr. Willard O. Thompson, Chicago, Illinois Therapeutic Advances in Endocrinology
- 3. Dr. Richard H. Freyberg, New York, New York The Treatment of Rheumatism and Allied Disorders

6:00 P. M.

Barbecue Supper

8:00-9:00 P. M.

Round Table Discussion—A question and answer program Moderator—Dr. O. H. Perry Pepper, Philadelphia, Pennsylvania

Saturday, November 6, 1948

10:00 A. M.

- 1. Dr. J. E. Moore, Baltimore, Maryland
 The Treatment of Symbilis
- The Treatment of Syphilis

 2. Dr. Willis J. Potts, Chicago, Illinois
 Special Surgical Problems of Children

2:00 P. M.

Football Game—Duke University vs. Wake Forest College

The Inurnal

of the

South Carolina Medical Association

VOLUME XLIV

November, 1948

Number 11

The Vaginal Spread: Its Usefulness As A Diagnostic Aid In 1000 Cases*

By
ROBERT E. SEIBELS, M. D., F. A. C. S.
Columbia, South Carolina

When the physician is advised¹ to take a routine spread for cytology studies on every female patient he examines as a diagnostic aid in the detection of early cancer of the uterus, he very naturally asks what results he can expect to achieve to make this added expense and effort worthwhile to himself and to his patient. In order to answer these and other questions this preliminary study of the incidence of uterine carcinoma in approximately 1000 cases is offered.

Two groups of patients are analyzed. The first group consists of patients from the author's private practice. The other group consists of patients of physicians in South Carolina, North Carolina and Georgia who have sent in spreads by mail for study.

Table No. 1 is an analysis of the studies made on the inside cases. Group 1 comprises 251 patients who had cytological interpretations from October 1, 1945, to January 1, 1947. During this period the studies were not made routinely. The majority of spreads were made on gynecological patients with assorted complaints and a few obstetrical patients who showed some deviation from the normal appearance of the cervix or who had some irregular bleeding. It must be emphasized that the studies were not restricted to those eases in whom we suspected cancer. In this group there were: one early, invasive, epidermoid careinoma of the eervix, Grade I, one early invasive epidermoid carcinoma of the cervix, Grade II (previously reported),2 and one adeno-acanthoma of the fundus.

Group 2, from January 1, 1947, to August 13, 1947, numbered 192. This represents the taking of routine cytology studies on every gynecological patient and those parturients whose cervices showed a deviation from a normal appearance. Among these was found

TABLE I
Incidence of Carcinoma in Inside Cases, with Cytologic, Biopsy and Pathologic Findings

	Number Patients	Positive Cytology	Biopsy Positive	Oper. Spec. Positive	Incidence
Group 1	251	3	2a	3	1.2%
Group 2	192	1	1	1	.5%
Group 3	231	4	3ь	4	1.7%
Group 4	99	1] c	1	1. %
TOTAL	773	9	7	9	1.1%

- a. Biopsy negative, operative specimen showed adeno-acanthoma of fundus.
- Biopsy negative, operative specimen showed preinvasive carcinoma of the cervix.
- Punch biopsy positive, wedge biopsy negative, operative specimen showed invasive carcinoma of the cervix.

one positive, adeno-carcinoma of the fundus, carly invasive.

Group 3, from August 13, 1947, to May 1, 1948, consists of 231 patients. These were routine studies made consistently on all new patients, both obstetrical and gynecological and included a few post partum cases where there were incompletely healed cervices. In this group four positive were found. Three were epidermoid carcinomata of the cervix, Grade I, and one adeno-carcinoma of the fundus.

Group 4, from May 1, 1948, to August, 1948, included all patients coming in for physical examination who had not had previous cytological studies in six months and all post partum cases. One positive was found in the 99 comprising this group.

[°]From the Bob Scibels, Jr., M.D. Memorial Laboratory

TABLE II

Incidence of Carcinoma in Outside Cases, with Cytologic, Biopsy and Pathological Findings

Number	Positive	Biopsy	Oper. Spec.	Not
Patients	Cytology	Positive	Positive	Operated
310	6a	.4b	1	5

- a. One case evident carcinoma, cells not recognized until biopsy specimen examined.
- b. One case clinically carcinomatosis, one case refused biopsy.

TABLE III
Symptoms or Signs in Proven Positive Cases

Symptoms or Signs	Epidermoid Carcinoma of Cervix	Adeno- Carcinoma of fundus	Adeno- Acanthoma of fundus
None	4	la	0
Irregular Bleeding Non-traumatic	2	2	1
Irregular Bleeding Post-traumatic	1	0	0
Eroded, or ulcer- ated Cervix	4	0	0
TOTAL	11	3	1

a. Normal regular periods at age 53.

The gradual increase in the indication for cytological studies was prompted by the finding of cancer among certain groups upon whom we had not been routinely taking the spreads. It has been our experience that looking at, palpating and otherwise examining the cervix is completely valueless in deciding whether or not it is the site of an early malignancy. Many cases in which we were so suspicious, both from the history of bleeding and the appearance and feel of the cervix, that we took biopsies at the time the cytology studies were made were completely negative for cancer. As is indicated in Table III only eleven of the fifteen cases that were found to be positive had either clinical findings or history suggestive of the possibility of malignancy. Four of the positive cases were devoid of symptoms or signs in any way suggestive of either malignancy or other uterine pathology. One of these was in the course of an apparently perfectly normal pregnancy and is reported below. Another was two months after a normal delivery with a slightly unhealed area on the cervix; biopsy from this area was negative; later other biopsies were positive.

When we examine Table II analyzing the cases sent in by other physicians, we do not find the expected higher incidence of cancer that might be anticipated since the majority of these spreads were made from patients with distinctly suspicious histories of bleeding with or without obvious ulcers or enlargement of the fundus. In this group the over all incidence of carcinoma is nearly two percent. However, if we

eliminate one patient with obvious carcinomatosis. whose slides were sent in as a matter of interest onlythe diagnosis being readily made clinically—we find in this group, nearly all of whom could be called "suspicious", an incidence of 1.6%. This is almost exactly the same as in our group 3 (all patients, both obstetrical and gynecological, except routine postpartum studies). These figures dramatically point to several fundamentals in the modern conception of uterine cancer, which force us to change our thinking in attempting to recognize cancer in its early stage. As has been demonstrated by Pund,3 "Preinvasive carcinoma (of the cervix) gives rise to no symptoms and cannot be detected by physical examination." In previous studies the same author4 reported on 1200 surgically removed cervices in which "preinvasive carcinoma was found in 47, an incidence of 3.9%. No preinvasive carcinoma was detected on gross examination (of the removed organ). Only 28% of those patients on whom adequate data were available had complained of some form of intermenstrual bleeding."

The carcinomata of the cervix that may be recognized clinically and demonstrated at operation or in gross pathology or in pictures are not early carcinomas. It is most unfortunate, but a natural consequence of this observation that the picture called to mind by uterine cancer among the majority of physicians is not early cancer but is advanced and probably questionably curable cancer. Preinvasive cancer of the cervix, which is the first stage of cancer, begins at the iunction of the stratified squamous epithelium covering the vaginal portion of the cervix with the single layer of columnar epithelium characteristic of the cervical canal. This juncture may easily be recognized in the normal cervix as it is the meeting place of the gravish epithelium of the vagina with the somewhat pink epithelium of the cervical canal. The lacerated, infected or eroded cervix may distort this juncture to the eye but not on microscopic sections as a rule. The cancerous change continues up the cervical canal and out into the fibrous tissue of the cervix and rather rarely appears on the surface of the vaginal cervix unti late in its life. The cauliflower growth seen either protruding from the cervix or replacing it, therefore, usually represents the third or fourth stage of its development.

Fundal carcinoma likewise in its early stages is not characterized by enlargement of the uterus, massive hemorrhage or constant bleeding. These are unfortunately the symptoms and signs which bring the possibility of carcinoma to the mind of the majority of examiners: these are not symptoms of early but of advanced endometrial cancer. Early carcinoma of the cervix and fundus are unfortunately without symptoms or signs in the majority of cases and the diagnosis must depend on the utilization of every possible means, including clinical observation, careful history taking and more particularly studies of the cytology, whether by the spreads or biopsy or both. 5

It has been observed that 60% of women with endometrial cancer continued to menstruate after age fifty, while only 15% of the women without the disease still menstruated beyond that age period.

At what age should one suspect cancer of the uterus? Again the general concept is in error because, as noted above, clinically demonstrable cancer is not early cancer. Pund and Auerbach4 found the average age of patients with preinvasive carcinoma of the cervix to be 36. In this study the youngest patient in the series was 24. Speert7 reported two cases, adeno-carcinoma of the cervix in a girl of 12 and epidermoid carcinoma of the cervix at 19. Pollack and Taylor8 collected thirty proven cases from the literature under twenty years of age, including twelve between three months and twelve years of age.

Should cytology supplant biopsy in the diagnosis of early malignancy? It is regrettable that this question should ever have arisen. There is no more conflict between evtology and biopsy than there is between the stethoscope, the microscope and the x-ray in the diagnosis of early tuberculosis. Many physicians admit that they do not do as many biopsies as perhaps they feel they should because of inconvenience and cost. While biopsy of the cervix or of the endometrium is a relatively simple procedure, once the method has been learned, and can be readily carried out in the office, it does take some special training and facilities not readily available to the non-gynecologist. Gathering material for cytology studies may be done by any physician without pain or inconvenience to the patient as a part of the routine examination of the cervix, and, indeed, can be done without the patient realizing that such a test is being made, and, therefore, having any apprehension while awaiting the report of the interpretation. The technique for the mailing method is outlined later in this paper. Positive cytological findings should of course, be confirmed by biopsy: endometrial, endocervical and of the squmo-columnar junction. In one case in this series two biopsies were negative, but hysterectomy was performed because of the positive cytology associated with cystocele and rectocele in a patient in the fifth decade. Carcinoma in situ was found in one block only, in the remainder of the cervix there was chronic cervicitis. This forcibly illustrates the observation that carcinoma does not originate in the entire cervix, but only in one focus, so that a biopsy may miss the area of neoplastic change by a few millimeters or by one-half the circumference of the cervix. On the contrary, occasionally we have found a few suspicious cells in the first cytological examination and several spreads on different days show no suspicious cells. This occurred in one case and the biopsy was positive. Subsequent cytology studies revealed hardly a low power field that did not show malignant cells.

In one case of carcinoma of the fundus the cytology was positive, associated with a history of postmenopausal spotting. Endometrial biopsy showed no malignancy. Examination under anesthesia showed no uterine enlargement. Routine curettage before administering radium showed a small area of adeno acanthoma.

In one patient with traumatic bleeding, ulcerated cervix, showing positive cytological findings, a punch biopsy showed definite carcinoma. A wedge removed with a scalpel to include the endocervix and portio was taken from the only area that subsequent sectioning of the operative specimen revealed to be free of carcinoma.

On the contrary, a negative cytology interpretation neither rules out carcinoma nor precludes the necessity for biopsy if other findings suggest it. In this series slides were sent in by a physician which we interpreted as negative: he very wisely did not let this deter him (all of our negative reports routinely carry the statement, "a negative report has not the diagnostic significance of a positive." This physician did a biopsy and found invasive carcinoma. On our reexamination of the slides, malignant cells were present. This was no failure of the science of cytology, but human failure to see intelligently what was there to be seen.

From October 1945 to about March 1946 the technique used was that modification of the original Papanicolaou method proposed by Papanicolaou and Marchetti9 and consisted of aspiration of cervical mucus through a small metal cannula attached to a syringe. For about a year this method was used exclusively and then the modification proposed by Ayre was adopted in the majority of cases, which consists of using a shaped wooden tongue depressor blade not only to secure mucous directly from the cervix but to get a scraping, or as Ayre¹o calls it, a "surface biopsy" of the superficial cells. We have modified this method slightly in having the spatula made of copper which is boiled with the instruments and can be used repeatedly. This spatula is rotated in the cervix with some pressure not only to pick up the secretions but some of the surface cells. The material is spread on two slides.

The method of interpretative procedure in the laboratory is as follows: after fixation and staining, all slides are examined, written descriptions are recorded and they are graded as normal, suspicious or malignant by the senior technologist. The author, without reference to the patient's name, history, or the previous interpretation examines each slide and elassifies it in one of the above classifications. Then he reads the report of the technologist. If they are in agreement, the case history is studied, and reexamination of the slides is made if indicated. In this manner two observers make individual interpretations without initial prejudice arising from physical findings or history. A negative history or lack of physical findings does not modify the interpretation: positive history or signs indicate a review of a negative report.

In this series 12,000 slides were examined in 700

working days and neither of the examiners spends full time on this phase of the work. The work of the technologist is estimated at three hundred and of the author one hundred working days.

In comparing the value of this and other routine laboratory studies it may be of interest that the 773 patients of the author all had serology tests for syphilis in the Laboratory of the South Carolina State Board of Health with the exception of those who had had a negative test in that laboratory in six months. In this group there were only three positive serologies and all three of these had given a history of infection and treatment: none of these were active and in need of treatment. There were in this group of patients no unexpected syphilities to compare with a minimum of four completely unexpected cancers.

This group to a very large extent would be typical of the patients consulting a general practitioner, as they were about equally divided between obstetrical patients and so-called gynecological patients. The latter group represents the whole range of female complaints and fifty percent of them could be classined as medical patients rather than gynecological patients. This fifty percent complained of nervousness, fatigability, hot flushes, overweight, amenorrhea in the non-pregnant, high blood pressure and domestic infelicity. The other fifty percent were made up of cases of infertility, irritating vaginal discharge, urinary discomfort, as well as straight gynecological problems, such as irregular bleeding, prolapsus uteri and the like. This series may be compared with the report recently by Fremont-Smith11 and Graham of their findings in the 308 patients coming to an internist. There was an incidence of carcinoma diagnosed by the spreads of 1.3%.

The following case illustrates the value of routine cytology studies in the absence of symptoms or signs. This patient, 32 years old, was examined on January 12, 1948, in her second pregnancy, the last period having been on October 12, 1947. No symptoms other than those of an early pregnancy were present. It was noted that the cervix was somewhat red, but not ulcerated. The variation in nuclear shape and size (Fig. 1) made us class this as suspicious and repeated spreads were made. This patient was kept under cytological observation rather longer than usual as we did not want to disturb her pregnancy, and some of the slides showed less atypical cells than others. On March 16, 1948, a punch biopsy (Fig. 2) revealed "preinvasive carcinoma of the junctional endocervix" (E. R. Pund, M. D., Department of Pathology, University of Georgia). The question immediately arose as to whether the pregnancy should be interrupted at once, or should be allowed to go to term, with abdominal hysterotomy, followed by a hysterectomy. Doctor Richard TeLinde and Doctor Nicholson Eastman of Johns Hopkins kindly acted as consultants (by mail) and suggested allowing the pregnancy to continue. Doctor Pund suggested curettage of the



Fig. 1.—Malignant Cells. Note nuclear variations.

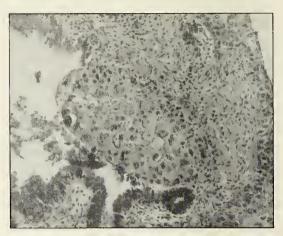


Fig. 2.—Biopsy.
Pre-invasive Carcinoma of Cervix.

endocervix to see to what extent the growth had gone up the canal. This was done on April 28, 1948, and showed definite limitation of the neoplasm to the vaginal endocervix. Coincidentally, she had a retroplacental hemorrhage, as we found out afterwards, a few days before, and several hours after curettage of the cervix she went into labor, delivering a premature non-viable infant. On May 29, 1948, hysterectomy was performed, removing the cervix with a generous cuff of the vagina. Tubes and ovaries were left in situ, no disection of broad ligaments or of the pelvis was done. Pathological report on the operative specimen (Fig. 3) is as follows: "Slight hypertrophy of the body of the uterus; area of coagulation necrosis involving the endometrium and underlying muscle 1.5 cm. broad, 4 cm. long and 1 cm. deep. The large vascular channels (placental site) are thrombotic. Healed bilateral lateral lacerations of the external os which is linear. Excess mucous activity of the endocervical glands. Preinvasive carcinoma of

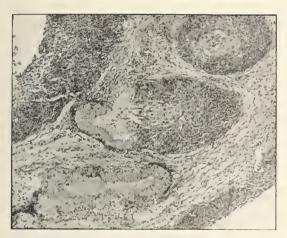


Fig. 3.—Operative Specimen.

Mouth of gland occluded by epithelioma.



Fig. 4.—Gross Specimen.

No evidence of malignancy macroscopically.

junctional endocervix involving the surface and mouths of a few glands and extending approximately 1 cm. into the endocervical canal. The neoplasm is present in five of six radial sections of the junctional cervix." (E. R. Pund, Department of Pathology, University of Georgia.) The photograph of the operative specimen (Fig. 4) shows absence of macroscopic change in the cervix.

A physician desiring to have a cytology study made may mail the specimen to a laboratory using the following method:

Instructions to the Patient: She should not have used any vaginal medications for twenty-four hours before the slides are taken, either suppositories or vaginal creams. However, if the patient has used something of this sort and lives out of the area, the physician can swab the cervix gently with a cotton pledget, as often the slides can be interpreted in spite of the treatment. If the patient lives in town and can

come back conveniently it would probably be better to have her make a return visit to be sure the staining of the cells would not be interfered with by the medication.

Method of Obtaining Spreads: Preceding bimanual examination a bivalve speculum is inserted into the vagina without any lubricant—any lubricant may cause interference with the staining reaction. Following adequate exposure of the cervix a wooden tongue depressor blade is pressed firmly against the cervix and rotated so that cervical secretion is obtained. This is spread on two slides, the area to be covered being about the size of a postage stamp. The slides are dropped while still wet into a solution of equal parts of 95% alcohol and ether. An ordinary paper clip attached to the slide will keep the slides from sticking together while in the alcohol ether mixture.

In the nulliparous and conical cervix the tongue depressor should be pointed somewhat by trimming with a knife so that it enters the cervix and scrapes the squamo-columnar junction.

The slides should remain in the alcohol ether at least one hour for fixation. After fixation the slides are lifted out of the mixture, but are not allowed to dry before two drops of glycerin are put on the smear side of each slide and a clean unused slide put on top of it, pressed down firmly. It is of the greatest importance not to allow the slides to dry once the secretion is put on them, either before putting them in the alcohol-ether mixture or afterwards.

History sheet forms and mailing containers may be obtaained from the laboratory.

Conclusion: We believe we have demonstrated that early earcinoma can be detected through cytological studies by a method which is free of inconvenience and simple so far as physicians and patients are concerned. We believe that the study amply demonstrates the efficiency of this procedure as a screening test to be used routinely. An incidence of from one to two percent of carcinoma in this series of patients is sufficiently large to make the test worthwhile both to the physician and to the patient.

We wish to acknowledge with gratitude the untiring helpfulness, inspiring encouragement and sound advice given to the laboratory by the following honorary consultants: J. Ernest Ayre, M. D., The Cytology Center, Montreal, Canada; Edgar R. Pund, M. D., Professor of Pathology, University of Georgia, School of Medicine, Augusta, Georgia; Henry H. Plowden, M. D., Pathologist, Columbia Hospital, Columbia, South Carolina.

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Outline of Essential Treatment of Bulbar Poliomyelitis

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(This paper was read at the First International Poliomyclitis Conference, in New York, July 12, 1948. It is essentially the same talk which was recently presented by Dr. Wilson before the Columbia Medical Society. It is of such interest at this time when poliomyelitis has been such a diagnostic and therapeutic problem that we are glad to publish it for the benefit of those who were not privileged to hear Dr. Wilson in Columbia.—Editor.)

One should not begin a discussion of the treatment of bulbar poliomyelitis without first spending a moment for definition of terms. The phrase, "bulbar poliomyelitis," is a bad one but so entrenched in medical terminology that we must continue to use it. It refers to the type of disease where the medulla is attacked, resulting in paralysis of one or more of the muscles innervated from that area, such as the pharynx, soft palate, larynx, facial muscles, or disturbances in the respiratory and vasomotor centers, ill-defined in position though they may be. The term, "bulbar poliomyelitis," does not refer to respiratory

muscle paralysis, that is, involvement of the diaphragm and intercostal muscles which are innervated from the cord. Many of the conditions resulting from involvement of the brain stem, however, can result in respiratory disturbances by other means than respiratory muscle paralysis.

We have a right to be insistent upon the importance of therapy in so-called bulbar poliomyelitis since the pharyngeal paralysis, as other bulbar palsies, is temporary and, if we can keep a patient alive for four or five days, in all probability he will survive and completely recover, at least from the pharyngeal paralysis. I will spend only a moment on general or systemic treatment. We obviously have no specific way to treat poliomyelitis in the acute stage, and this is as true of brain stem involvement as of the spinal disease. Many attempts have been made to reduce the effect of the virus on the central nervous system both by dehydration and overhydration of the brain. Although still used, it seems to me that there is little evidence that can stand analysis that these procedures

have been effective. As is well known, attempts to influence the course of the disease by specific scrum treatment also have been carried out many times. None of these therapeutic adventures has been proved successful by a critical analysis of controlled observations and, accordingly, I will not discuss them further.

Wherever there is respiratory difficulty, oxygen may be of value. The use of oxygen-enriched atmospheres certainly will increase the alveolar concentration of oxygen and, where there has been previously a defect due to faulty respiration, this defeet will be corrected. However, it must be remembered that oxygen therapy will not aid the other function of respiration, that is, the excretion of carbon dioxide. There is a great tendency to resort to an oxygen tent or oxygen therapy as a panacca for any respiratory difficulty and, although the oxygen in itself cannot do harm, reliance on oxygen alone and incarceration of a patient in an oxygen tent where he cannot be closely and minutely observed and other treatment carried out may result in much more harm than good. Since there is no specifie or effective systemic treatment, we must resort to symptomatic treatment and, even although not specific, such procedures as are possible are of extreme importance and can often make the difference between life and death. The treatment of bulber poliomyclitis is probably more important and effective than the treatment of any other type of poliomyelitis during the acute stage.

I must emphasize that one cannot intelligently consider treatment of the various circumstances in "bulbar" poliomyelitis without spending a great deal of time in exact differential diagnosis of the complex symptoms that we see. Discussion of this problem has been covered. Although vasomotor disturbances and other ill effects may result from involvement of the brain stem in this disease, I will confine my discussion to a consideration of the respiratory difficulties. This will not include paralysis of respiratory muscles innervated obviously from the upper part of the spinal cord.

Although different palsies occur in the same patient, nevertheless, for clear thinking, we must discuss the therapy of each type of involvement separately. We will, therefore, discuss the treatment of the effects of pharyngeal paralysis, of laryngeal paralysis, and of respiratory center involvement, even though at times it may be extremely difficult to differentiate the overlapping and interlocking effects of these various disturbances.

The treatment of pharyngeal paralysis can be summarized by listing briefly the Do's and Don'ts. Under "What Should Be Done," we consider postural drainage and aspiration of the pharynx of first importance with the possibility of tracheotomy always under consideration. Under "Don'ts," we would emphasize the danger of oral feeding or gavage or the use of atropine or of sedatives. The purpose of the treatment of pharyngeal paralysis is to furnish a free airway for

effective respiration, first, by keeping the pharynx so free of secretions that pulmonary aspiration will not take place and that the patient will be able to relax and to sleep and, second, if the first is impossible, by tracheotomy. We should be most fearful, first, of aspiration of secretions or vomitus with consequent attacks of anoxia, which will greatly influence the course of the disease for the worse and, second, of the serious ill-effects of accumulative fatigue which in itself probably can be very serious.

Postural drainage should always be effected. By postural drainage we mean real postural drainage with the head at least a foot lower than the feet, and sometimes carried out to such an extent that the patient has to be tied by his feet to the bed to keep from sliding ont. He is often benefitted by being on his side or on his face with his face turned to one side. With many patients, however, postural drainage will not result in such complete drainage of secretions that there is no interference with respiration.

The next step in the treatment of pharyngeal paralysis is the use of aspiration. Aspiration of the throat should be carried out with effective apparatus, operated at a pressure not too great to be traumatizing and with a suction tip that can be placed precisely where one needs it. A great deal of attention should be given to the teclinique of aspiration as a patient can be brutally abused by it. Aspiration must be carried out with extreme carefulness, yet with firmness and effectiveness. Too powerful suction ean traumatize the mucous membranes. Too frequent and vigorous use of the aspirator will greatly disturb or frighten the patient and can cause nausea and retching. Fear of the aspirator can neutralize its good effects. In a child, for instance, the apparatus at first must be introduced gently around the guns and the lips so that the child becomes accustomed to it before it is finally placed where it is most effective, at the root of the tongue just above the larvnx. I, myself, prefer a rigid metal aspirator that can be placed where one wants it. In certain cases of moderate severity, the procedure can be carried out more satisfactorily by the patient himself. I have seen this successful in a seven year old boy.

A patient should not be given any food or fluids by mouth. The temptation to gavage patients is great as it seems simple to introduce food and fluid in this manner when there is nothing wrong with the stomach. The danger is too great, however, to permit such a procedure to be carried out. It is dangerous because of the great tendency for "bulbar" patients to vomit with consequent choking and eyanotic attacks and subsequent increase in secretions. Adequate prevention of ketosis and maintenance of body fluids can be carried out by rectal taps or by the parenteral administration of fluids during the acute stage of the disease, and gavage should not be resorted to until the patient is afebrile and hungry and past the danger stage. A constant intravenous drip is very

useful but not without danger from too large dosage of fluids. It is probable that overhydration may increase cerebral edema and, if a mistake is to be made, slight dehydration is probably preferable. Probably 1/3 to 1/2 the fluids should be saline and the rest 5% glucose.

Atropine has seemed to some doctors useful in drying up sccretions. I believe it is harmful as it only makes the secretions thick and sticky and harder to remove without completely eliminating them. It also has an adverse effect upon the heart rate, which is in danger of escaping from vagal control anyway in this disease.

The use of sedatives such as morphine or barbiturates to permit rest is just as dangerous as in any case of laryngeal obstruction or respiratory obstruction. The patient cannot be permitted to rest as long as every respiration has to be calculated. If rest cannot be obtained by postural drainage and aspiration and, if choking attacks still occur, tracheotomy is probably indicated.

Tracheotomy: Tracheotomy is a radical step but often life saving. Its purpose is to furnish a free airway so that the air necessary for respiration does not need to be moved down a pharvnx full of secretions and through a larynx continually in spasm. Tracheotomy is often dramatically effective. One need not comment on the dangers of tracheotomy such as from pneumothorax and infection, although the latter danger is lessened now with our effective antibiotics. One should attempt to carry out tracheotomy long before severe choking attack or attacks of cyanosis make it obviously necessary as a last desperate attempt to save life. The indication, therefore, depends upon the success of the other two forms of treatment, postural drainage and aspiration, in keeping the pharynx clear. Although the pharynx may be clear enough by these techniques to prevent only oceasional choking, if it cannot be kept clear enough so that the patient can also get rest, a tracheotomy should be carried out. One should consider the seriousness of the situation in a patient with pharyngeal paralysis whose every breath must be a consciously calculated and planned one, with inspiratory muscles continually alerted to a sudden expiration, which will be initiated by even slight aspiration. Such a patient gradually develops such extreme fatigue that he eventually lapses into unconsciousness even if this state has not resulted from aspiration and anoxia. These dangers must be prevented at all costs.

There has been a recent wave of enthusiasm for tracheotomy. A tracheotomy most certainly is not necessary for every case of pharyngeal paralysis in poliomyelitis. In fact, in my experience, it is necessary in only a small fraction of all "bulbar" patients. There are many cases of palatal paralysis which simulate pharyngeal paralysis where obviously it is not necessary. Frequently, good results from careful and critical medical eare can be obtained without resorting to a

tracheotomy, but constant observation during the first few hours of contact with the patient is necessary to make it evident whether or not it will be necessary.

In case of the majority of patients with mild or moderate brain stem involvement, successful treatment depends considerably on one's ability to get them to relax. One must make a serious effort toward avoiding excitement and giving a patient confidence. An otherwise simple situation can be rapidly changed for the worse when physicians and other attendants rush in an excited way around a room, hang a patient up by his feet to give him postural drainage, and thrust aspirators into his throat vigorously with an air of excitement. Although I realize the difficulty in distinguishing the results of treatment from the effects of the progressive disease itself, I believe fear in a patient will greatly prejudice his outcome. A calm but certain worker with an attitude of confidence can do a great deal to make the simplest means of treatment of this disease effective. In certain patients one can tell in a very few moments that they are going to be so tense that they will not easily submit to effective aspiration of the throat. Such a patient will probably need a tracheotomy. In deciding upon this important step, therefore, evaluation of a patient's emotional stability is just as important as any other part of the physical examination. Because of the very great emotional disturbance that some patients exhibit, it is tempting to resort to sedatives. It is doubtful that sedatives are ever justified because one is always uncertain how much of the excitement and fear is something that could be alleviated by a sedative and how much is actually due to anoxia or fatigue, as a direct effect of pharyngeal paralysis. Under such circumstances, a patient cannot be given the luxury of rest and a tracheotomy will be necessary.

Although there is room for differences of opinion, in my own experience it is wise to carry out the tracheotomy under an anesthesia and in children, at least, avertin has seemed rather ideal. The excitement of trachcotomy done under local anesthesia can be followed by such rapid increases in the rate of the heart that one cannot avoid the feeling that it is a direct result of too great trauma and emotional stimulation.

Laryngeal paralysis: We will not spend much time in the discussion of this feature. It is rare and it is difficult to diagnose. It can be most accurately diagnosed by laryngoscopy, but that in itself can be dangerous unless one is prepared to follow it right away with a tracheotomy. Obviously, equipment for effective aspiration should be available. Where it can be determined that a paralysis of the adductors that leads to inspiratory obstruction is present, it is obvious that a tracheotomy is clearly and immediately indicated.

Involvement of the respiratory centers: As far as we know, there is no single respiratory center. Its position has not been accurately anatomically defined. Nevertheless, due to the grossly irregular or curiously slow breathing or hiccough-like respirations, it is obvious in some patients that the central control of respiration is at fault. However, it is often extremely difficult to distinguish the irregular and disturbed respiration under these circumstances from that which results from unswallowed pharvngeal secretions, which continually interrupt respirations and prevent a normal rhythm in patients with pharvngeal paralysis. I have some doubt that a tracheotomy will often prevent the ill effects of a disturbed respiratory center which otherwise would lead to death. Usually the differentiation can be made readily enough, however, either after observation of the attempts to swallow a tiny amount of water or because of the clearly evident gurgling respiration which results from pharyngeal paralysis. In case of doubt, one may feel justified in going through all the radical steps of the handling of pharvngeal paralysis with tracheotomy even though death may soon follow.

It must be clear that obviously none of our treatments can be effective in all cases of "bulbar" poliomyelitis and, with our present state of knowledge, death all too frequently is inevitable.

Much more could be said about the techniques of many procedures that have been outlined. How should oxygen be administered? With a tracheotomy, it is quite easy to administer oxygen with various types of apparatus such as a small cone over the tracheotomy opening. The greatest problem in any situation where there is a tracheotomy is to give the oxygen while at the same time leaving free access for observation of plugging of the tracheotomy tube with secretions and for aspiration.

It is not my intention to discuss the use of the respirator here since, ordinarily, it is rarely effective in any of the situations which result from bulbar poliomyelitis, although occasionally a depressed respiratory center with slow regular breathing may be greatly helped. One has to keep in mind, however, that not infrequently respiratory muscle paralysis with clear indication for the use of the respirator exists simultaneously with pharyngeal paralysis. It is sometimes difficult to differentiate these, although it can be done in most instances readily enough by careful and intelligent and experienced observation. In pharyngeal paralysis, a patient may frequently breathe for some time as if the diaphragm were

paralyzed or his intercostal muscles could not move, only to take a sudden deep breath which makes it clear that that has not been the situation. With pharyngeal paralysis, the patient seems to breathe in many curious patterns in an attempt to prevent aspiration. However, too frequently it may be necessary to carry out the treatment of "bulbar" poliomyelitis in a patient who is also in the respirator. The inconvenience of a respirator and a tracheotomy tube at the same time is obvious. The older respirator machines were made with a slanting front to make it easy to carry out a tracheotomy. The newer ones are much more difficult to use though some attempts have been made to modify them for this purpose. A few cuirass type respirators are available which fit some patients and, when they can be used satisfactorily, they do enable the treatment of pharyngeal paralysis to be much more readily carried out. We can only hope that such devices will be developed soon in an improved form.

It is extremely difficult to evaluate therapy of brain stem poliomyelitis by statistical analysis and comparison of mortality figures. We are forced to use our common sense and knowledge of physiology to decide whether or not we are accomplishing anything, and we must admit that conclusions based on such evidence are dangerous. We have in poliomyelitis the best example of any disease, where many therapeutic adventures have been undertaken and enthusiastically followed, only to be later discarded. The spontaneous variations of this disease are very great. Details of the characteristics of the disease vary in epidemics. The use of the diagnostic term "bulbar" varies. If we include under bulbar palsies every patient with a facial or palatal paralysis, no matter how slight, we are going to get a low mortality, no matter what form of therapy is carried out. In any single case the degree of involvement of the vasomotor and vagal centers, to mention only those that we begin to understand, cannot be evaluated. A patient with evidence of only mild paralysis of the pharynx may die rapidly, with a very rapid pulse and apparent terminal cardiac and vasomotor failure. We must remember that we have recourse only to symptomatic palliative treatment. A failure of direct effect from the essential features of treatment outlined in this report, that is, postural drainage, aspiration, or tracheotomy cannot be considered proof that these procedures were unwisely undertaken.

Drug Laws

THOMAS D. WYATT State Drug Inspector Spartanburg, S. C.

I have been invited to speak to you tonight on drug laws. We are all, more or less familiar with the different laws, rules and regulations pertaining to these laws. The first and the most important thing to remember in regard to these laws is the purpose for which they were enacted. Not to regulate the practice of medicine or pharmacy but as a protective measure for public health. There is no intent to interfere in any manner with the physician or pharmacist in the legitimate practice of his profession.

The most important of these regulatory drug laws are the Barbiturate laws, the Dangerous Drug Laws and the Narcotic Laws. With your permission I will take these three up separately.

THE BARBITURATE ACT

In 1938, the General Assembly of the State of South Carolina enacted this law and placed the responsibility of enforcement under the State Board of Health. However, due to an oversight or some other reason, no appropriation was made to take care of the expense incurred in the enforcement. After several years of being kicked around the Executive Committee of the Board of Health made arrangements with the Board of Pharmacy for the State Drug Inspector to take over the duties of checking on this law. An advisary committee was appointed by the Executive Committee, consisting of two physicians and two pharmacists to meet with the State Health Officer to draw up rules and regulations and make other recommendations for the proper enforcement of the Act.

This program as recommended, consisted of press releases, radio talks, personal contacts, and a copy of the law with rules and regulations, accompanied by an explanatory letter, mailed to every physician, dentist, veterinarian and pharmacist in the state, asking their co-operation. Tonight I am happy to say, that we have had wonderful co-operation from the legitimate professional men of the state, and I am proud to tell you that South Carolina has the best record in drug law observance of any state in the union.

The Barbiturate Law provides for the sale of Barbituric Acid preparations and their compounds, only on the prescription of a physician, dentist or veterinarian, or a person authorized to prescribe narcotic drugs.

The law prohibits the possession of this class of drugs by any person other than a physician, dentist, veterinarian or authorized person under the Act, unless the package containing the drug bears a pre-

(This paper was presented by request at a meeting of the Pee Dee Medical Society in Florence, September 16, 1948.) scription label with the prescribers name and address and the dispenser's name and address, and adequate directions for use. Nothing in the Act shall be construed to prohibit or limit licensed physicians, dentists or veterinarians from dispensing barbiturates in the regular course of their practice, except however, upon any such barbiturate being dispensed by a physician. dentist or veterinarian, so much of such barbiturate not to be consumed in the presence of the person dispensing, same shall be placed in a container bearing the name and address of the prescriber and dispenser. In other words, the physician may dispense a dose of a barbiturate, but if he leaves several doses for the patient he must place a label on the container bearing his name and directions for taking. To fail to do this would be a violation on the part of the physician and would place the patient in the position of having illegal drugs in his possession.

Under rules and regulations promulgated by the Secretary of State, August 22, 1947, we find only four such regulations:

- It shall be required that all prescriptions for barbiturates and barbiturate compounds, not exempt by the Act shall be filed on a separate file from regular prescriptions.
- 2. A prescription for barbiturates or barbiturate compounds not exempt by the Act may not be refilled during the period of the specified dosage, after which, it may be refilled twice within sixty days of the original prescription unless the prescriber specifies "do not refill".
 - (Under no condition may the prescription be refilled exceeding the prescribed dosage unless so specified by the physician.)
- 3. A prescription for barbiturates or barbiturate compounds received over the telephone may be dispensed provided the signature of the prescriber is obtained within seventy two hours of the date of the prescription. The physician, dentist or veterinarian prescribing the barbiturate shall be equally liable with the dispensing pharmacist to see that the prescription is signed by him within the prescribed time.
- Barbiturates not exempt by this Act may be dispensed only by a licensed pharmacist, assistant pharmacist, or under the direct supervision of a licensed pharmacist.

You have noticed mention of exempt preparations under the Act. These exempt preparations are Barbiturate Compounds, containing not more than one-fourth of the standard dose of the Barbituric Acid preparation which in combination with active medicinal ingredients, the activity of which will preclude

the use of the compound to obtain the full effect of the Barbituric Acid.

THE DANGEROUS DRUGS ACT

This law was enacted by the General Assembly last year and was placed under the supervision of the Board of Pharmacy. In purpose and intent it is uniform with the Federal Acts relating to Pure Food and Drugs.

The Act reads: It shall be unlawful for any person, firm or corporation to sell, giveaway, barter, exchange, distribute or possess in the state of South Carolina, sulfanilimide, sulfathiazole, sulfapyradine, sulfadiazine, prontolin, pyramidon, aminopyrine, atophan, chloral, paraldehyde; abortifacient drugs, such as ergot, cotton root cantharides; amphetamine or compound thereof; (except in denatured inhalers); harmones, synthetic or natural, antifat preparations to include thyroid, thyroxin or such other drugs which are now or hereafter declared dangerous by the Federal Food and Drug Administration, and which are, in the discretion of the Board of Pharmacy of South Carolina, classified as "dangerous drugs" within the meaning of the Act; except on the prescription of a duly licensed physician, dentist or veterinarian, and such prescription shall be compounded only by a registered pharmacist, registered assistant pharmacist, or under the direct personal supervision of a registered pharmacist. No such prescription shall be refilled except upon authorization of the prescriber.

The receipt of numerous requests from drug manufacturers, Physicians and Pharmacists for a list of those drug products which are considered dangerous when sold otherwise than on the prescription of a physician, dentist or veterinarian licensed by law to administer drugs, has caused the Pure Food and Drug Administration to point out that the Act places upon the manufacturer and the distributor, the responsibility for properly safeguarding the marketing of drugs which may be dangerous to the purchaser if distributed without restriction. Obviously, it is impossible to list all drugs which may be dangerous, since not only the composition, but also the directions for use and the conditions in which their use is recommended, may have a very definite bearing on the question of safety or danger.

When the legend "Caution, to be used only by or on the prescription of a physician" appears upon the package in lieu of directions for use, it is the obligation of the pharmacist to observe the injunction that the article be dispensed only upon prescription.

It is unlawful to offer for delivery, for pay or otherwise, any drug that is adulterated or misbranded after its receipt in interstate commerce. The pharmacist, therefore, assumes a direct responsibility when dispensing or selling drugs over the counter. No pharmacist with an appreciation of responsibility by reason of his relationship to the public, and the confidence that consumers will place in his advice, may ignore

the warning placed upon the label of a dangerous drug intended to restrict its distribution indiscriminately.

The refilling of prescriptions for potent drugs should be authorized by the physician. The patient requiring the administration of potent drugs should be under the continuous care and supervision of the physician while these drugs are needed.

DRUGS DISPENSED BY PHYSICIANS

I quote from the Pure Food and Drug Administration, "It is our opinion that a physician who does his own dispensing is also acting in the capacity of a pharmacist and may avail himself of the exemption provided by the section if he fulfills all the requirements of the section."

From this we must conclude that the physician may dispense a potent drug, provided he labels the drug with adequate directions for use and warnings of misuse.

RECORDS TO BE KEPT

Again I quote from the Pure Food and Drug Administration, "The dispenser must either retain the physician's prescription or a satisfactory record of the prescription. The physician, if he dispenses the drug, must retain in his possession a record of the article prescribed.

Barbiturates are also classed under "Dangerous Drugs" by the Federal Pure Food and Drug Administration and bear the label "Caution, to be used only by or on the prescription of a physician."

HARRISON NARCOTIC LAW

The Harrison Act was passed by Congress December 17, 1914 and became effective March 1, 1915. A short time later the General Assembly of South Carolina enacted the Uniform Narcotic Act. The Federal Act is under the supervision of the Treasury Department and is primarily a revenue Act. The South Carolina Narcotic Act, uniform with the Federal Act is placed under the supervision of the Health Department, and is a Criminal Act.

It is unnecessary to go into detail as to the procedure to follow to become registered under this Act, other than to state who is eligible for registration under the Act to prescribe and dispense Narcotic drugs. Only lieensed physicians, dentists, and veterinarians are eligible for registration to prescribe and administer narcotic drugs. Licensed pharmacists are the only ones to dispense, with the exception of physicians, dentists, and veterinarians, in the regular course of their practice.

RIGHTS AND DUTIES OF THE DOCTOR

There has been some mis-understanding between physicians and pharmacists on several points in the Narcotic Act.

A physician may write a prescription for anything he desires in the way of narcotic drugs, provided the prescription is written for a bona-fide patient. He may obtain the preparation in the drug store and act as the common carrier to take it to his office to be later administered or given to the patient, or he may deliver it to the patient at home. There is nothing in the law that prohibits the physician from obtaining either for legitimate medicinal use. However, a physician may not write a prescription to obtain narcotic drugs and divert them to his own use, either to replenish his office supply or stock his emergency case.

A physician must be in personal attendance upon a patient to write a narcotic prescription. Under no circumstances may he give absent treatment. No record is required to be kept of the narcotics he personally administers. However, if he does leave narcotics with the nurse or other person, to be administered in his absence, he must make a notation of the amount in his record book giving the patients name and address and date.

A prescription must be issued for legitimate medical purposes. The responsibility for the proper prescribing and dispensing of narcotic drugs is upon the practitioner, but a corresponding liability rests with the pharmacist who fills the prescription. I quote from Article 167, "An order purporting to be a prescription issued to an addict or habitual user of narcotics, not in the course of professional treatment, but for the purpose of providing the user with narcotic drugs sufficient to keep him comfortable by maintaining his customary use, is not a prescription within the meaning and intent of the Act; and the person filling such an order, as well as the person issuing it, may be charged with violation of the law."

There is no intent to interfere with the physician or pharmacist in cases where physicians prescribe for diseases commonly known as incurable, such as cancer, advanced tuberculosis and other diseases in this class, provided he is directly in charge of the case. Mere addiction, however, is not recognized as an incurable disease.

Narcotic prescriptions must be written in ink, or with an indellible pencil or typewritten, never with an ordinary lead pencil. The prescription may be written by a nurse or other agent but must be signed by the physician prescribing.

A great many people are under the impression that a narcotic prescription must be filled on the date written. However, there is nothing in the law which states the time that must clapse between the time a prescription is written and when it shall be filled.

Telephoned prescriptions, I quote from Article 172;

"The furnishing of narcotics pursuant to telephone advice of practitioners is prohibited, whether prescriptions concerning such order are subsequently received or not, except that in an emergency a pharmacist may deliver narcotics through his employee or responsible agent pursuant to a telephone order, provided the employee or agent is supplied with a properly prepared prescription before delivery is made, which prescription shall be turned over to the pharmacist and filed by him as required by law."

Mailing narcotic prescriptions by physicians after delivery is made by the pharmacist is not allowed.

This has been the most prevalent violation of the narcotic laws we have in South Carolina. Under the law the pharmacist or his agent, must receive the signed prescription before delivery is made. The physician should leave the signed prescription either at his office or at the home of the patient so that the pharmacist may comply with the law. The lack of proper co-operation has caused the pharmacist to be placed in an embarrassing position many times. If the pharmacist refuses to accept the 'phoned prescription, the physician hangs up the phone in disgust and calls another pharmacist who is overly anxious for business, and is willing to enter a technical violation with the physician. Here I quote from another Federal statute:

"Anyone who aids, abets, causes or persuades another to violate a Federal Statute, is guilty of a conspiracy."

I urge you, as physicians, to give your patient just a few more seconds of your time and sign their prescriptions for narcotics, barbiturates and dangerous drugs. Cooperate with your pharmacist in upholding the laws for the protection of Public Health.

The Journal of the South Carolina Medical Association

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Please send in promptly notice of change of address, giving both old and new; always state whether the change is temporary or permanent. Original manuscripts, subject to approval by the Editor and the Editorial Board, are desired for publication in the Journal. They should be typewritten, double spaced, on 8½ x 11 paper. References should be complete, and only such as relate directly to statements quoted in the paper. Illustrations will be used as funds permit, or as authors are willing to bear the necessary increase in cost. Short original articles are preferred to long reviews.

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THANKSGIVING

It is appropriate that we should pause for a period at this time of year and list some of the things for which we are truly thankful—

We are thankful that our country is still at peace. We are thankful for a material prosperity which is greater than that of any other nation in the world today.

We are thankful that we live in a country which still enjoys the four great freedoms.

We are thankful that in a world in which there is so much suffering we are still able to give of our substance toward the alleviation of that suffering.

We are thankful that we belong to a profession which is still imbued with the goal of serving others.

We are thankful for health and strength which enables us to carry on our daily task.

Accept our thanks, O Great Physician, and give us the will to work and the capacity to serve, in Thy Name.

SOUTHEASTERN REGIONAL CONFERENCE

The South Carolina Medical Association recently served as host to the annual Southeastern Regional Conference and the event was highly successful, Unfortunately the invitations were sent out a little late and the dates conflicted with a number of other medical meetings, with a resulting fewer number in attendance than had been hoped for. The program itself, however, was good. Physicians who attended were given the opportunity to hear the problem of medical care discussed by various individuals outside of the profession itself-a distinctly refreshing and stimulating experience. In addition to those from this state, there were physicians from five other southern states in attendance-and this gave a regional tone and spirit to the occasion. An abstract of the addresses given will be published in this Journal for the benefit of those who were unable to be present.

CENTENNIAL DIRECTORY

At long last the Centennial Directory has been printed and a copy is now in the hands of each member. Of necessity there may be an occasional error and for this we are sorry. If any such error is found we request that a note concerning this be sent in immediately so that it will not recur in future issues.

The publication of such a Directory is no mean task and requires both time and money. Whether such a Directory should be published each year will depend upon the wishes of the members, and we invite comment

A small number of extra copies were printed and these are available upon request—fifty cents per copy to members of the Association, \$1.00 per copy to non-members.

PEE DEE CENTENNIAL

We wish to congratulate the Pee Dee Medical Association on the occasion of its one hundredth birthday and to commend the society for the splendid way in which the event was celebrated.

Over one hundred physicians from over the state were present for the meeting. The afternoon session consisted of addresses by the sons of the Pee Dee who have made a name for themselves in the world of medicine: Dr. Oscar Bethea of Tulane University, Dr. Louis Buie of the Mayo Clinie, and Dr. Eugene Pendergrass of the University of Pennsylvania. Dr. R. B. Durham, President of the South Carolina Medical Association, brought greetings from that body.

The evening period consisted of a social hour, a banquet, and an address by Dr. Buie.

The Pee Dee Association is proving the worth of district medical societies. Each county in the area still has its own medical organization, but the members from all seven counties join together once a month for a scientific session. The programs are good, the attendance better than average, and the morale excellent. Other district societies in the state might take a leaf from the minutes of the Pee Dee Association and attempt similar meetings.

A MEDICAL SERVICE PLAN

Now that a Hospital Service Plan (i. e. Blue Cross) is now operating well in this state it is incumbent upon our Association to explore the possibilities for the establishment of a Medical Service Plan (i. e.

Blue Shield) in South Carolina. At the last meeting of the House of Delegates the matter was brought to the floor for discussion and was referred to the Council for further study and specific recommendations. Council is well aware of its keen responsibility in this matter and has already met to lay the groundwork for future study and action. When it is considered that South Carolina is one of the few states in the union that does not have some type of medical service plan in operation, we begin to realize the necessity for our Association to act. Present indications are that Council will bring specific recommendations to the House of Delegates for the establishment of such a plan in the near future. Before such recommendations are presented, however, each member of the Association will be given ample opportunity to study the proposals and to see for himself just what is involved.

TWOSCORE YEARS

It was just twenty years ago this month that we began the practice of medicine in South Carolina. Just twenty years—a single grain of sand on the scashore of eternity. And yet twenty years which are probably as momentous as any similar period in the history of man.

As our mind travels back over those twoscore years, here are some of the things which stand out: the depression, bank closures, patients with sickness but little money, Hoover fading from the national scene and Roosevelt dashing to the front, the hectic days of the beginning of the New Deal, the N. R. A., the A. A. A., and the host of other alphabetical agencies, the slow uphill pull out of the depression, the W. P. A. with its good points and its terrible squandering of money, the hectic battles in the halls of Congress, the advent of chemotherapy and of the antibiotics, the early signs of war, Pearl Harbor, our members volunteering for service, Procurement and Assignment Service, the hardships experienced by our members in uniform, the never ending work of those who stayed at home, rationing, the inauguration of our own Ten Point Program, the list of casualties and the horror of war brought to us, the threat of Federal Medicine, the loss of some of our own members on the battle field, the atomic bomb, the joy of welcoming our colleagnes back home, the founding of the United Nations, great hopes for peace, high prices, the threat of Russia on the horizon, uncertainty, the possibility of World War Three.

Twoscore years—what does the next twenty years hold in store for us?

DIABETES DETECTION DRIVE

The finding of the million unknown diabetics in this country poses a direct challenge to the American doctor. It is within his power to accomplish this feat. The existence of a million undiscovered diabetic patients in the United States has been demonstrated through a series of surveys, the most recent one conducted by the United States Public Health Service. The results of these studies now provide a spring-board for organized medicine and a golden opportunity for physicians to seize the initiative on their own in this significant phase of public health.

The American Diabetes Association has planned a campaign to promote the early discovery and prompt treatment of the million undiscovered cases of diabetes. This campaign is unique in professional service, for according to plan the physician himself will be at the helm. Therefore, the plan cannot be prosecuted, or even started, without the endorsement and support of the entire medical profession through its governing bodies, national, state, county and local medical societies.

The plan proposed by the Association is simple, direct, and sure. Through local diabetes associations, related to the American Diabetes Association and with cooperation of local, county and state medical societies over the United States and Canada, it is planned to carry out blood-sugar screening tests by a new five-minute micro-blood sugar method with simultaneous urinalysis for sugar with attention to the time in relation to the preceding meal. The procedure can be carried out apart from a formal laboratory. The equipment is still in the manufacturers' hands but is to be available within two or three months. The only provision will be that the candidate must name a physician or clinic to which the results of the tests will be mailed for interpretation to the patient. Under no condition will a report be sent directly to the examinee. The effort is to bring the unknown diabetic patient under his own physician's care. There will be no statistics; no red tape.

Simultaneously, the American Diabetes Association will carry on an intensive educational campaign directed first toward doctors' post-graduate courses. It will be directed toward the layman by radio, newspapers and other publicity channels in addition to the "A.D.A. Forecast," the Association's bi-monthly magazine which brings to the diabetic patient home-spun articles on the disease by eminent authorities in the field. At the same time the Association will place in the hands of physicians over the country an authentic "Handbook of Therapy". Containing the most up-to-date information available, the Handbook will assist the physician in treating diabetic patients.

The week of December 6-12, immediately following the interim meeting of the American Medical Association, will be proclaimed as "Diabetes Week". This will be the formal beginning, the kick-off, of the Association's Diabetes Detection Drive. From this start, the program will continue on a long-term basis.

The Association is determined to do its part in finding these million individuals and guiding them to you, their physicians, for treatment. May we count on your support when the matter comes up before your county or local medical society? The success or failure of the Diabetes Detection Drive depends upon you. *You* stand at the helm; this is *your* project.

Sincerely yours, Howard F. Root, M.D. Chm. Committee on Diabetes Detection, Amer. Diabetes Association

THE TEN POINT PROGRAM

M. L. MEADORS, EXECUTIVE DIRECTOR AND COUNSEL

SOUTHEASTERN REGIONAL CONFERENCE

The Southeastern Regional Conference on Medical Service for 1948 was held at the Columbia Hotel in Columbia on October 12th and 13th. An annual affair for the past three years, the Conference met in 1946 and 1947 in Atlanta. South Carolina and the South Carolina Medical Association were fortunate in having this State and its capital city selected as the site for the meeting this year.

A number of outstanding speakers were included on the program and hearty approval of the work of the Conference generally, was expressed by those present.

The meeting was opened on Tuesday afternoon, October 12th, with an address of welcome by Dr. R. B. Durham, President of the South Carolina Medical Association. On Tuesday evening, beginning at 6:00 o'clock, Dr. and Mrs. Durham entertained the members of the Conference and their guests at their beautiful home "Sleepy Hollow," near the city.

The Tuesday Session was devoted to Rural Medical Service. Mrs. Wilma B. Sledge, Social and Educational Director for the Mississippi State Farm Bureau Federation, discussed "Rural Health Problems and Methods of their Solution." From a wide practical experience with the subject in her home state, she gave a most interesting resume of the difficulties encountered in the effort to extend proper medical service to all the rural population of Mississippi, and of the steps which have been inaugurated and are now in progress toward meeting them. She emphasized the extent to which the shortage of hospital facilities, nurses and physicians' services are inseparably related to each other and to the shortage of financial resources, in preventing the rendition of totally adequate service.

Dr. William R. Pretlow of Warrenton, Va., discussed the operation of medical and hospital prepayment plans in rural communities. One of the founders of Virginia Medical Service (the Medical Prepayment Plan in Virginia) and now a member of its Board of Trustees, Dr. Pretlow, who practices in what he described as one of the most completely rural counties of Virginia, showed how the non-profit prepayment plans designed to make medical and hospital service more available to the lower income group could be made to operate on a sound, satisfactory and practical basis in farming areas as well as in the urban centers of population.

Concluding the afternoon's program, Dr. R. V. Platou, head of the Department of Pediatrics in the Medical School of Tulane University, described very interestingly the type of survey now being conducted by him and his associates at Tulane, throughout ten counties in southern Mississippi, for the purpose of determining the extent of the availability of medical care and hospitalization, the existing need, and particularly, the points at which additional medical service and facilities for treatment are essential. Accompanying his remarks by a number of slides showing graphically the findings thus far, Dr. Platou indicated that in the opinion of those engaged in making the survey, the matter of supplying the needs would follow more or less automatically once the survey is complete.

Wednesday's program included prominently two South Carolinians who have done excellent work in their respective fields and who presented their subjects ably. The theme of Wednesday morning's program was "Problems of Health in the Southeastern States" and its treatment approached by five speakers from as many different angles.

Dr. C. L. Guyton, head of the Division of Hospitals of the South Carolina Department of Health, now engaged in administering the program for hospital and health center construction under the terms of the Hill-Burton Act, described in detail what is being done in South Carolina along this line. He pointed out many of the practical difficulties and the minimum requirements that must be met in supplying treatment facilities, if the plan and purpose for which the Federal and State funds were appropriated are to be accomplished.

Miss Katherine Edwards, now Principal of the elementary schools of Greenville, with a record of long experience in school work, spoke in a most interesting manner of the practical side of health problems among school children. Some of the deficiencies she pointed out as existing in the equipment and training facilities of some rural schools were, to put it mildly, surprising and, in some instances, rather astonishing. From her own experience, Miss Edwards made it clear that a teacher alert to the reaction of her pupils, can generally tell when all is not right with them from a health standpoint, and that the teacher should be encouraged to concentrate upon detecting and lending her aid in the improvement of the child in this respect as well as

from the standpoint of its mental training. The chief emphasis of her discussion was upon the fact that problems of this sort will have to be solved primarily by two groups; the teachers and the physicians. Both of these professional groups with background, viewpoint and occupation so directly related to the physical and social well being of the people must recognize, she pointed out, and concentrate upon discharging the responsibilities for which their training and professional status have fitted them.

Mr. Cicero W. Kendrick of Atlanta, a prominent leader of organized labor and official of the Georgia State Federation of Labor, gave one of the sincerest and soundest appraisals of the situation as seen through the eyes of one in his official position that it has been our good fortune to hear in a long, long time. Mr. Kendrick pointed out that labor as a group is just as vitally interested as any other in preserving the freedom and independence of the American way of life and that employees recognize that their welfare depends upon the welfare of the employer. This mental attitude, however, and that of other groups, does not alter the fact that many, many people, he said, are without adequate medical care and hospital service, through circumstances beyond their immediate control. He made it clear that while he did not favor a system of state medicine such as has been often discussed, he believed that this might be the ultimate result unless some other solution is found. He called upon the medical profession to furnish the leadership in finding such a solution and pledged the co-operation of labor and other lay groups in any movement reasonably calculated to relieve the situation.

Dr. John T. T. Hundley of Lynchburg, Va. presented the results of a survey conducted by him a few months ago in determining what the lay public generally thinks of the adequacy of available medical care and the things which need most to be changed to improve it. Dr. Hundley, who is a practicing physician, specializing in internal medicine, sent requests to a large number of individuals in various occupations and strata of society, requesting their estimate of doctors and the service rendered by them. Some of the replies he received were enlightening and highly interesting, if not always entirely complimentary. As a matter of fact, however, the attitude consistently expressed by the majority of those who replied was one of favorable inclination toward the medical profession; and the faults most frequently pointed out were in matters which, with a little care and attention on the part of the individual doctor, could be readily improved.

Dr. Hundley's paper was somewhat in the nature of a realization of the wish expressed by Robert Burns, "wad some power the giftie gie us to see oursels as ithers see us."

Comments on the subject from the standpoint of a Washington observer were given by Dr. Joseph S. Lawrence, who is in charge of the Washington Office of the AMA Council on Medical Service. From his vantage point at the hub of government activities with respect to medical and hospital service, Dr. Lawrence brought valuable observations regarding the probable future trends. He called attention to the numerous bills introduced in the last Congress, some of which were passed, affecting one phase or another of the subject of medical care for all the people. It was his belief that the movement toward compulsory health insurance under government control has been arrested for the time being.

Concluding the treatment of the subject and speaking from the viewpoint of a leader in organized medicine, Dr. Walter B. Martin of Norfolk, Va., a member of the Board of Trustees of AMA outlined the steps taken by the National Organization within the past few years in its active program to preserve the free system of the practice of medicine. He stressed the Ten Point Program of the American Medical Association adopted and now in process of execution. This, he believed, if properly activated and extended should go far toward answering criticism leveled at the profession in the past and remedy most of whatever defects exist in the system of medical service, which has always been a part of Democratic free American institutions.

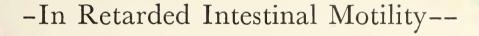
Following luncheon at 1:00 o'clock at which the members of the Conference were guests of the South Carolina Medical Association, the session was resumed, the afternoon being devoted to general discussion, led by Mr. Thomas A. Hendricks, of Chicago, Executive Secretary of the AMA Council on Medical Service and Dr. Fred C. Hubbard of North Carolina.

The two days meeting was attended by representatives of the medical associations of North Carolina, Virginia, Georgia, Florida, Tennessee and Louisiana. The total number registered was 53 and the general concensus of opinion seemed to be that the program arranged was successful in focusing thought and presenting prepared discussions upon those subjects of most vital interest to the profession, in its quest for an answer to the questions which have been so prominent in the minds of the public, during the past few years. No formal action was determined upon, and none was proposed by the Conference. The ideas expressed were for the further consideration of the delegates in their respective state groups, and for activation wherever possible, according to the means most adaptable in each area.

The arrangements for the conference were in charge of a Committee composed of Dr. Julian P. Price, Chairman; Dr. Walter B. Martin and Dr. H. B. Mulholland, Dean of the University of Virginia Medical School, Charlottesville and a member of the AMA Council on Medical Service. Dr. Mulholland presided at the first day's session and Dr. Price on Wednesday.

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RESEARCH IN THE SERVICE OF MEDICINE

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in which to sample the advantages, disadvantages, and shortcomings of the National Health Service. Most practitioners would agree, we believe, that the month has brought fewer changes than they feared. It is true that, for many of them surgeries have been unusually heavy; but some of the extra work will not have to be repeated. Patients uncertain of their rights, or how to obtain them have come to ask questions, or to hand in forms. Others have waited for July 5 before presenting themselves to have their eyes tested, or their minor operations arranged. Private patients who formerly had repeat prescriptions filled by pharmacists now come to have each prescription written on the official form; but in course of time this additional labour will be reducible by prescribing, in some of the cases, medicine of a type or quantity that will demand less frequent repetition.

"Administratively the initial stages proceed steadily and with surprisingly few hitches. The final count of doctors joining the service will not be known until allowance can be made for those whose names now appear on the lists of more than one executive council, and for those who have joined the service to secure their right to compensation, but who for reasons of age or infirmity, or because they now intend to specialize, will soon be retiring from general practice. Even now, however, it is safe to say that enough doctors have joined to provide in all areas an adequate service. The patients have not been backward in completing their application forms, and the number of patients on doctors' lists is already said to approach 90 percent of the population. The cards have come in quickly and many an executive council office has found it hard to keep pace with its inordinately heavy daily intake. Some delay is inevitable while patients' cards are sorted, counted, and recorded, and one cannot expect the new record cards to arrive immediately after dispatch of the application forms. What is less excusable is that stocks of prescription and certificate forms received by executive councils before the appointed day have sometimes been insufficient to meet the practitioners' needs, and that schemes are announced for opting out superannuation, and for claiming compensation, before executive couneils possess the memoranda and application forms that will enable practitioners to make their claims.

"The rapid enrolment of so high a proportion of the public has only too quickly revealed the uneven distribution of doctors. Reports from some underdoctored areas tell of doctors with lists already more than saturated, while from others come reports of groups of doctors faced with unexpectedly small lists, and shrinking incomes, spontaneously approaching the newly formed Medical Practices Committee with requests that their particular area shall be declared overdoctored and closed to the entry of further practitioners. Evidently the committee's purpose, as well as its personnel, has been tacitly accepted, and it has quietly embarked on its tasks.

"Patients have been confused. In particular, the

simultaneous launching of a National Health Service. participation in which is optional, and a National Insurance scheme, compulsory under penalty for most families, has led to every permutation of misunderstanding. But it does now seem that the relatively high rate of weekly insurance contribution which has become payable has been the determining factor which has decided so many to enter so quickly. Conversely, a remarkably high proportion of elderly people have said that, as no direct weekly contribution is being asked of them they feel it unfair to avail themselves of the benefits to which they are entitled. It is probable that many who so far have not signed cards will do so if in the ensuing months they need medical care. The fact that medicines cannot be supplied at the expense of the service to any but enrolled patients has brought many, and will continue to bring others, into the service. It will be surprising if the estimated 98 percent of acceptances in the first two years is not reached long before this term is up.

"July began with very unseasonable weather which did nothing to improve health or the temper of the British public. The incidence of infectious illnesses, too, seemed somehow to linger on this year, and the load of measles, mumps, and chicken-pox remained greater than usual. Nevertheless, we have got through the first month without undue disturbance, and the months that follow should allow the new service to get well into its stride before it has to bear the burdens of winter."

"The First Month," The Lancet, August 7, 1948.

FREE DIAGNOSTIC CLINICS

Dr. Harry S. Mustard, long prominent in public health work, is well-known to South Carolinians, especially to members of the South Carolina Medical Association. A native and one-time resident of Charleston, with family connections there and elsewhere in the State, Dr. Mustard last year served as President of the American Public Health Association, at the same time holding the chair of Public Health at Columbia University.

In a short interim among his varied activities in 1947, Dr. Mustard took time to come to South Carolina and conduct a survey of the State Health Department, at the request of the Committee of Seventeen appointed by the Council of this Association. The purpose of the survey was to enable the officers of the Medical Association to intelligently counsel with the legislative leaders of the State with respect to proposals for changes in the Health Department, and as a result, the Association was directly in touch with proposed legislation introduced, but not adopted, at the last session of the General Assembly.

More recently Dr. Mustard has been serving as Health Officer for the City of New York. His appointment to that post is further evidence that his knowledge of the subject is not simply theoretical, and of his ability to deal with the problems of public health from a practical standpoint. The following

THE ATLANTA GRADUATE MEDICAL ASSEMBLY

JANUARY 24, 25, 26, 1949

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Dr. Albert C. Broders

Dr. George Crile

Dr. Lester R. Dragstedt

Dr. Ross Golden

Dr. E. C. Hamblen

Dr. Walter Kempner

Dr. Oswald S. Lowsley

Dr. John S. Lundy

Dr. W. F. Mengert

Dr. William C. Menninger

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editorial from the New York Times of August 13, 1948, describes one interesting project originated by him, which has gained recognition by the press and public:

"Physicians of this city have long been accustomed to referring their poorer patients to the Health Department's Bureau of Tuberculosis for X-ray studies and to other bureaus for laboratory aid in diagnosing tropical, venereal, nervous, cardiac and dental diseases. Now Dr. Harry S. Mustard announces that a 'pilot' clinic will soon be established for the extension of these services as well as for periodic health examinations. The need is pressing. Ten years ago the late Dr. S. S. Goldwater described some eighteen diagnostic procedures which were necessary in what he called 'a typical neurological case' and which called for the opinions of about sixteen specialists and laboratory technicians. The cost was not stated. It could hardly have been less than \$250. Because of the higs cost of making the most of that which medical science has to offer in identifying an affliction-90 percent of good medicine is good diagnosis-physicians hesitate to send their needy patients to commercial laboratories. Dr. Mustard's free 'pilot' clinic will come to their rescue. From it much can be learned that should be invaluable in extending diagnostic service to cover the whole city.

"Only patients referred to it by their own physicians will receive the new clinic's diagnostic attention, whereupon they will be sent back to their physicians for treatment. The bitter controversy that has been raging for twenty years over what is unhappily called 'socialized medicine' might give way to peace and understanding if the city and the country would go farther. Suppose we had free diagnostic clinics in every community-clinics to which anyone could go at any time for a thorough physical examination by a staff which has all the necessary technical aids at its disposal for the identification of any disease or affliction. Suppose that the finding reads 'diabetes,' 'hypertension,' or some chronic disease. Would a patient who is sufficiently concerned about himself to visit the clinic in the first place fail to report the findings to his own physician and undergo a course of treatment? The physician would still retain his patient, who is his bread and butter, and the patient would be spared the necessity of spending what are to him impossibly large sums for laboratory tests. The free diagnosis might indicate a way of reconciling the views of organized medicine and those who see in compulsory health insurance the only way of bringing good medicine to all the people."

AMERICAN HOSPITALS

Almost 18 million Americans were admitted into the 6,173 hospitals of the United States in 1947, according to the 1948 American Hospital Directory compiled and published by the American Hospital Association. This represents an average of one of every eight Americans receiving hospital care. Approximately 16 million patients, two million more than in 1946, were admitted to general hospitals during the year, the Directory reports. In addition, 40 million hospital visits were made by outpatients, those needing special tests or treatments without bed care.

The average cost of caring for a patient for one day in a general hospital rose from \$9.39 to \$11.09 in the year 1946-1947; yet the average income from patients was \$9.71, leaving a daily deficit of \$1.38 per patient to be made up through voluntary contributions and gifts from the public. Part of the \$2,354,344,000 expended by hospitals in 1947 was for the salaries of the 79 fulltime employees serving every 100 patients in all types of hospitals. General hospitals had approximately 151 employees for every 100 patients to maintain prevailing high standards of patient care. Hospitals spent about 400 million dollars more in 1947 than in 1946, because of higher wages, higher prices, and expanded services.

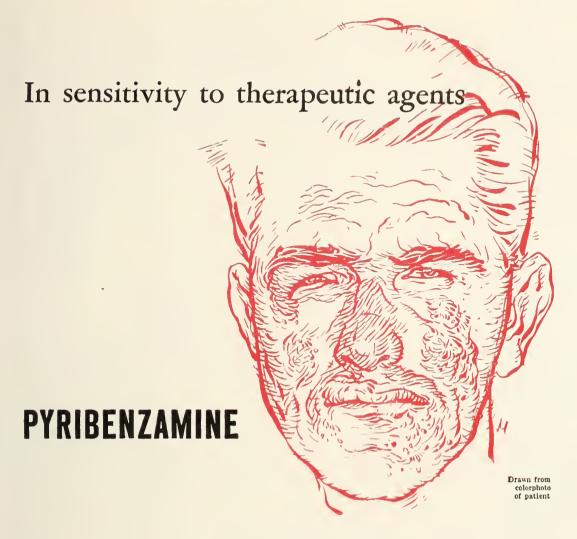
The average patient going to a general hospital in 1947 stayed for only eight days, as compared with 9.1 days in 1946, the figures show. This reflects the spreading practice of entering hospitals in earlier stages of illness, possible for increasing numbers of people through Blue Cross and other prepayment plans, as well as wider recognition of the value of hospitals, improved treatment methods, and early ambulation.

Hospitals in 1947 had total assets of approximately six million dollars, which is more than \$42 for every man, woman and child in the United States. Of that amount, general hospitals' plant valuation represents almost three and a half billion dollars, an average of \$7,500 per bcd.

"Ten years ago, in 1937, 9,221,517 patients were admitted to hospitals," George Bugbee, executive director of the American Hospital Association reported. "During this ten-year span, hospital admissions have increased almost 100 percent. The facts revealed by the Association's survey," he said, "dramatically illustrate the increased recognition of the place of hospitals in the nation's health and welfare." Medical science and hospital care continue to progress steadily, Mr. Bugbee stated, and added that "while not always as dramatic or as attention-getting as other developments in other areas of scientific advances, they do have a personal meaning for every individual in America. The prospect is for better, longer and healthier lives."

ELECTION DAY

By the time this appears Election Day of 1948 will be history. The election, despite the possibility and many predictions of a tie-up in the Electoral College will, in all probability, have been determined. This, of course, refers to the event itself. The results, however, will still remain to be seen. Not simply the four years



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beginning January, 1949, but also the whole future course of our national life, may be affected by the result of the voting on November 2nd.

Nor will it be possible for the medical profession to know on November 3rd with any degree of certainty what the future holds for it. Any who look forward to the advent of a Republican administration with a sense of relief, feeling it will bring a cessation of the agressive efforts toward complete socialization of medicine, we believe are seeing a mirage. As we have pointed out before, the record of Governor Warren of California on the subject is too well established to be forgotten immediately, and whatever may be the plans and purpose of the occupant of the White House for the next four years, the laws are passed by Congress and the forces moving in the direction of State Medicine are too well organized and too determined to be turned back overnight.

Speaking at a recent conference in Chicago, attended by representatives of the medical and dental profession, from all over the country, Congressman Fred E. Busbey, a member of the House Committee on Expenditures in the Executive Department said in part, "Many Americans today are smug and complacent. They say that the November election auto-

matically will solve all of our problems. This thinking exists among many physicians and dentists in this country—'The Wagner-Murray-Dingell Bill is dead and so the threat to our profession has passed.' Nothing could be further from the truth. Nothing could play into the hands of our enemies more surely and definitely than that kind of thinking."

Speaking to the same gathering, Dr. Claude Robinson, Research Analyst, Partner of George Gallup of Gallup Poll fame, and President of Opinion Research Corporation, put it this way: "As has been remarked here before, 'Now that Governor Dewey is going to be elected everything will be solved.' Well, that is a very naive point of view because politics do follow the grass roots. I don't care whether they are Republican politics or Democratic politics, the job here is to create in the public's mind grass roots symbols which will reflect themselves in the thinking of your representatives in Washington and in the state capitols. There is no other security than that."

The point made by these speakers, we think is well taken. It will be just as necessary that we be on the alert and active after January 1st as it is today, regardless of the outcome on November 2nd.

DEATHS

WILLIAM DUNCAN GRIGSBY

Dr. W. D. Grigsby, 68, died at a hospital in Columbia on the morning of September 28 after an illness of a few days.

Dr. Grigsby, a native of Kershaw County, received his education in the schools of Blaney, Leesville College, and the Medical College of the State of South Carolina (Class of 1906). He had practiced medicine at Blaney for the past forty-two years and was one of the community's most beloved citizens.

He is survived by his widow, the former Miss Lillian Burns of Charleston; two brothers, and three

sisters.

PHILIP WILLIAMS HUNTER

Dr. Philip W. Hunter died at his home in York on September 29, following a long period of declining

health. He was 63 years old.

Dr. Hunter received his education in the local schools of York, at Kings Mountain Military Academy, and was graduated from the Medical College of the State of South Carolina in 1911. For thirty-four years he practiced medicine at York and won the love and respect of all who knew him. During World War I he served with the British Army throughout the war. He was captured by the Germans and held prisoner for nine months. He was awarded the Military Cross of Great Britian, the highest honor the British Empire could bestow upon an American citizen. In World War II he served as commanding officer of the York Home Guard unit.

Dr. Hunter is survived by five sisters.

GOODMAN BARE

Dr. Goodman Bare, 54, died suddenly at his home in Starr on October 1.

Born in North Carolina, Dr. Bare received his medi-

cal training at Emory University School of Medicine (Class of 1920). He was Health Officer for Anderson County at the time of his death.

Dr. Bare is survived by his widow and two sons.

ROBERT FULTON ELVINGTON

Dr. Robert F. Elvington, 64, died at his home in Lake View on October 5. A native of Lake View, Dr. Elvington was graduated from the Medical College of South Carolina (Class 1912). He began the practice of medicine in Lake View in 1914 and continued this up until 1935 when he was forced to give up active work on account of his health.

Dr. Elvington is survived by two daughters and

three sons.

NEWS ITEMS

Dr. George Dean Johnson of Spartanburg, has announced the association of Dr. Samuel E. Elmore, Jr. with him in the practice of pediatrics.

Dr. R. M. Paulling has opened his offices at 91 Rutledge Avenue, Charleston, for the practice of orthopedic surgery.

Dr. Walter D. Hastings, Jr., has opened offices in the Montgomery Building, Spartanburg. He is limiting his practice to general surgery.

Dr. Gordon Spivey has accepted the position of Medical Director of the Carolina Life Insurance Company. He replaces Dr. Herbert Dove who has resigned.

Dr. J. D. Gilland of Kingstree, has recently been elected a Fellow in the American College of Surgeons and was initiated into the organization at its recent annual meeting in Los Angeles.



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ABSTRACTS

Dumphy, J. E., & Hoer, S. O.: The Indication for Emergency Operation in Severe Hemorrhage From Gastric or Duodenal Ulcer, Surg. 24: 231-238 August, 1948

The authors believe that the rate of bleeding is the factor above all others which governs the outcome on conservative management rather than the age of the patient, the number of previous hemorrhages and other considerations which have been used as an index. A clinical rule to assist in recognizing the rate of bleeding is as follows: if the rate of bleeding is such that stable circulation cannot be maintained with transfusions roughly approximating 1500 c.c. of blood per 24 hours, spontaneous cessation of the hemorrhage is unlikely and emergency operation should be undertaken.

The source of bleeding in the upper gastro-intestinal hemorrhage must be known. About 20% are esophageal varices or gastritis and are not amended by emergency surgery. If the source is not obvious clinically or by previous examination, then x-ray examination of the esophagus, stomach, and duodenum should be made preoperatively. If these methods demonstrate no lesions, it is wiser to withhold surgery.

Patients were arbitrarily divided into four classes: 1. Those who ceased to bleed soon after admission as evidenced by examination and hematocrit studies were not considered for operation. 2. Those who continued bleeding after admission but required only 500-1000 c.c. of blood per day to maintain stability. 3. Those presenting evidence of shock and requiring 1000-1500 c.c. of blood per day for stabilization of circulation were not immediately operated upon. Sometimes 1000-2000 c.c. of blood were required for circulating stabilization during the first few hours of hospitalization, and thereafter 500 c.c. given every 8 hours. 4. If at any time after initial stabilization of circulation, and under transfusion regime, syncope, shock or merely sharp rise in pulse rate or lowering of blood pressure occurred, the patients were considered in a precarious situation and operation seemed safer than expectant management with an even more rapid rate of transfusion.

A comparison of results of treatment at the Pcter Bent Brigham Hospital during the period 1946-1947 and during the preceding 6 years (1940—through 1945) when there was no systematic approach to the problem showed the mortality rate to have been decreased from 7.6% to 2.2%. There were no operative deaths in the period 1946-1947.

It is emphasized that a patient who is in shock on

arrival at the hospital or develops evidence of it while under treatment, deserves the constant vigilance of a bedside team of internist and surgeon.

Ochsner, Alton: Venous Thrombosis, Surg. 24, 445-451, Sept., 1948

Thrombophlebitis and phlebothrombosis differ in etiology, pathology, clinical manifestations, prognosis and therapy. Thrombophlebitis is inflammation of the venous wall with an intravascular clot; whereas, phlebothrombosis is characterized by an intravenous clot unassociated with inflammation of the venous wall.

In both types of venous thrombosis the main precipitating factor is stasis in the venous circulation. Bed rest, increased intra-abdominal tension from the use of tight abdominal bandages in patients with gaseous distention of the intestines compressing the vena cava, and shallow respiration all favor venous stasis.

Symptoms of thrombophlebitis are fever, pain, coldness, whiteness and swelling of the extremities. The fever is the result of the inflammatory process involving the venous walls; the other manifestations are the result of ischemia caused by arteriolar spasm. These symptoms are likely to persist unless adequately treated. Emboli are unlikely to occur because the clot is attached to the venous wall.

Phlebothrombosis is accompanied by few or no manifestations. Slight elevation of temperature associated with elevation of the pulse rate is suggestive. When compression of the calf or foot is painful and forceful dorsal flexion of the foot causes pain in the calf and popliteal area (Homan's sign), a diagnosis of phlebothrombosis can be made.

Although the patient with thrombophlebitis has severe symptoms and may have persistent disabling sequelae, there is little danger to life. On the other hand, in phlebothrombosis there may be few or no manifestations but an embolic fatal outcome is always a potentiality.

The treatment of venous thrombosis is primarily prophylactic. Atraumatic surgical technique, active movement of lower extremities and deep breathing exercises all lessen the danger. The curative treatment for thrombophlebitis consists of vasodilatation secured by anesthetizing the regional sympathetic ganglia with procaine hydrochloride. A technique of injection is described. Ligation of the vein is done only when suppurative thrombophlebitis is present.

Because the thrombus is not attached to the venous wall in phlebothrombosis, it is imperative that either thrombectomy be done or the vein ligated above the thrombus. A technique of both is described.

The Abundant Nutrient Values of **B VITAMINS** COMPLETE FOOD KIND OF MEAT PROTEIN THIAMINE (B.) RIBOFLAVIN (B.) NIACIN IRON EXCELLENT EXCELLENT FAIR EXCELLENT EXCELLENT PORK EXCELLENT FAIR EXCELLENT **EXCELLENT EXCELLENT** RFFF **EXCELLENT** FAIR GOOD EXCELLENT EXCELLENT **EXCELLENT** GOOD GOOD EXCELLENT EXCELLENT VEAL EXCELLENT EXCELLENT EXCELLENT EXCELLENT EXCELLENT VARIETY MEATS (LIVER MEAST, KIOMEY) EXCELLENT GOOD EXCELLENT GOOD GOOD SAUSAGE (FRANKFURTERS, ROLOGNA)

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of grade or cut, makes these contributions.

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PUBLIC HEALTH NEWS

MISS CUNNINGHAM TO RETIRE

Miss Nellie C. Cunningham, executive secretary of the South Carolina State Nurses' Association, has resigned her post effective at the annual meeting of the Association to be held October 7-9 at Charleston. She will be succeeded by Miss Carol J. Clements, supervising nurse of the Richland County Health Department.

Miss Cunningham received her A. B. degree from Winthrop College, and after teaching for five years, took nursing training at the Savannah Medical Hospital in Savannah, Georgia, graduating in 1912. She came to the State Board of Health in 1919 and in 1921 went to Columbia University for her B. S. degree, returning to the State Board of Health in 1923,

She served as assistant head of the Bureau of Child Hygiene from 1930 to 1933, when she was made chief

clerk of the Bureau of Vital Statistics.

She became executive secretary of the Nurses' Association in 1935, and has served in that capacity from that time. She is also executive secretary of the State Board of Nurses' Examiners.

Miss Clements, who has requested a year's leave of absence from the State Board of Health, is a native of Georgia. She is a graduate of William and Mary College, Richmond, Va., and of the University Hospi-tal, Augusta, Ga. She received post graduate training in supervision theory at the Medical College of Virginia.

Since coming to the State Board of Health in 1920, Miss Clements has served as nurse in Fairfield, Edgefield, and Abbeville Counties and as supervising nurse

in Anderson and Richland Counties.

TWO NEW HEALTH CENTERS

Two community health centers in Orangeburg County, one at Holly Hill and the other at Branch-ville, were formally opened for public use on Friday,

September 24.

Large crowds attended the two dedication ceremonies and were taken on a tour of inspection through the buildings by personnel of the Orangeburg County Health Department. Cake and punch were served by committees of local women. Representatives of the State Board of Health who attended the opening ceremony in Holly Hill were dinner guests of Dr. L. D. Wells.

Dr. Ben F. Wyman, State Health Officer, who was principal speaker for both ceremonies, commended the people of the localities for their enterprising community spirit which made the centers possible.

INCIDENCE OF POLIOMYELITES 1948

	Total Cases	October
County	Total Cases Jan.—Oct. 20	
Aiken	JanOct. 20 4	Cases
Anderson	10	1
	10	
Bamberg	<u>2</u> 3	
Barnwell	3	$\frac{\overline{2}}{1}$
Beaufort	4	2
Charleston	15	1
Cherokee	15	
Chester	10	
Chesterfield	9	
Clarendon	3	$\bar{1}$
Colleton	3 1	
Darlington	2	1
Dillon	4	ï
Dorchester	3	î
Edgefield	2 4 3 5	î
Fairfield	6	•
Florence	6 8	1
Georgetown	ĭ	
Greenville	$2\overline{5}$	- <u>-</u>
Greenwood	6	J
Greenwood	Total Cases	October
County		
County	Jan.—Oct. 20	Cases
Horry	Jan.—Oct. 20 13	
Horry Kershaw	Jan.—Oct. 20 13 7	
Horry Kershaw Lancaster	Jan.—Oct. 20 13 7 13	
Horry Kershaw Lancaster Laurens	Jan.—Oct. 20 13 7 13	
Horry Kershaw Lancaster Laurens Lee	Jan.—Oct. 20 13 7 13 8 8 5	
Horry' Kershaw Lancaster Laurens Lee Lexington	Jan.—Oct. 20 13 7 13 8 5 9	
Horry' Kershaw Lancaster Laurens Lee Lexington Marion	Jan.—Oct. 20 13 7 13 8 5 9 4	
Horry' Kershaw Lancaster Laurens Lee Lexington Marion Marlboro	Jan.—Oct. 20 13 7 13 8 5 9 4 4	
Horry' Kershaw Lancaster Laurens Lee Lexington Marion Marlboro Newberry	Jan.—Oct. 20 13 7 13 8 5 9 4 4 4	Cases
Horry' Kershaw Lancaster Laurens Lee Lexington Marion Marlboro Newberry Oconee	Jan.—Oct. 20 13 7 13 8 5 9 4 4 4	
Horry' Kershaw Lancaster Laurens Lee Lexington Marion Marlboro Newberry Oconee Orangeburg	Jan.—Oct. 20 13 7 13 8 5 9 4 4 4 2 9	Cases
Horry' Kershaw Lancaster Laurens Lee Lexington Marion Marlboro Newberry Oconee Orangeburg Pickens	Jan.—Oct. 20 13 7 13 8 5 9 4 4 4 2 9 6	Cases
Horry' Kershaw Lancaster Laurens Lee Lexington Marion Marlboro Newberry Oconee Orangeburg Pickens Richland	Jan.—Oct. 20 13 7 13 8 5 9 4 4 4 2 9 6 31	Cases
Horry' Kershaw Lancaster Laurens Lee Lexington Marion Marlboro Newberry Oconee Orangeburg Pickens Richland Saluda	Jan.—Oct. 20 13 7 13 8 5 9 4 4 4 2 9 6 31	Cases
Horry Kershaw Lancaster Laurens Lee Lexington Marion Marlboro Newberry Oconee Orangeburg Pickens Richland Saluda Spartanburg	Jan.—Oct. 20 13 7 13 8 5 9 4 4 4 2 9 6 31 1	Cases
Horry Kershaw Lancaster Laurens Lee Lexington Marion Marlboro Newberry Oconee Orangeburg Pickens Richland Saluda Spartanburg Sumter	Jan.—Oct. 20 13 7 13 8 5 9 4 4 4 2 9 6 31	Cases
Horry Kershaw Lancaster Laurens Lee Lexington Marion Marlboro Newberry Oconee Orangeburg Pickens Richland Saluda Spartanburg Sumter Union	Jan.—Oct. 20 13 7 13 8 5 9 4 4 4 2 9 6 31 13 6 4	Cases
Horry Kershaw Lancaster Laurens Lee Lexington Marion Marlboro Newberry Oconee Orangeburg Pickens Richland Saluda Spartanburg Sumter Union	Jan.—Oct. 20 13 7 13 8 5 9 4 4 4 2 9 6 31 13 6	Cases
Horry Kershaw Lancaster Laurens Lee Lexington Marion Marlboro Newberry Oconee Orangeburg Pickens Richland Saluda Spartanburg Sumter	Jan.—Oct. 20 13 7 13 8 5 9 4 4 4 2 9 6 31 13 6 4	Cases
Horry Kershaw Lancaster Laurens Lee Lexington Marion Marlboro Newberry Oconee Orangeburg Pickeus Richland Saluda Spartanburg Sumter Union Williamsburg	Jan.—Oct. 20 13 7 13 8 5 9 4 4 4 2 9 6 31 1 13 6 4 3	Cases

BOOK REVIEWS

CLINICAL LABORATORY METHODS AND DIAGNOSIS R. B. H. Gradwohl 4th Edition. Three volumes C. V. Mosby Co. (St. Louis)

Gradwohl's Clinical Laboratory Methods and Diagnosis has always kept astride the continual growth of modern hospital laboratories. The new 4th edition in three volumes gives complete coverage of all the latest procedures.

The detailed yet concise information is of equal

value to the student technician and graduate alike. The comprehensive and all inclusive scope of the text is of such type and character that specialists in medicine and its related sciences are amply repaid in using this text as a constant reference. Present methods of education are met by the clinical and laboratory data which are woven together to depict clear, concise patterns. Heretofore, one has not hoped to find such a wealth of material in any other three volumes or under one author. The pathologist, whether he employs all graduate technicians or has a training school may have an invaluable aid on all current techniques

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Loryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Loryngoscope, Jon. 1937, Vol. XLVII, No. 1, 58-60; Broc. Soc. Exp. Biol. and Med., 1934, 32,241; N. Y. State Journ. Med., Vol. 35, 6-1-25, No. 11, 590-592.

^{*}Completely documented evidence on file.

^{**}Reprints on Request:

and their interpretation by having Gradwohl in his

library

Although this book is presented for general laboratory procedures the material is not given in isolated The wealth of the text is in the correlation of the laboratory findings and the clinical picture. The entire context is devoted to the aim of keeping warm and viable an appreciation of the importance of the fundamental aspects of laboratory procedures to clinical medicine. The discussions are so comprehensive and yet so clearly presented that the pattern of pathological physiology readily comes to the mind of the specialist in any branch of medicine.

It is refreshing to note a repetition of the preface to the first edition quoting the words of Dr. Victor C. Vaughan "that he who practiced medicine without the aid of a laboratory belongs to a past generation of

physicians.

When we remember that Sir William Osler said "As is our pathology so is our medicine," one can only speculate on the enthusiasm with which this great

physician may have received these volumes.

These three volumes of Dr. Gradwohl and his collaborators have by and large succeeded in placing emphasis upon the team-work which is necessary without over-stressing the importance of the diagnosis of clinical conditions by laboratory procedures. The triumvirate of clinical manifestations, physical findings and laboratory data are lucidly integrated.

I. W. McM.

CORRESPONDENCE

Dr. Ben F. Wyman State Health Officer Columbia, South Carolina

Dear Dr. Wyman:

The Public Health Service has decided as a matter of policy to discontinue its own routine production of vaccine which can be obtained from commercial manufacturers of biologics products. The chick embryo type vaccine for Rocky Mountain spotted fever, which has been produced and distributed by the Rocky Mountain Laboratory in the past, is now being manufactured in adequate quantity by two commercial con-cerns, the Lederle Laboratories, Pearl River, New York, and Sharp and Dohme, Philadelphia, Pennsylvania. Production of this vaccine at our Hamilton Laboratory has now been terminated. In the future, it will be necessary for health agencies and practicing physicians to supply their needs for vaccine from these or other commercial concerns which may become engaged in its manufacture.

The tick tissue type of spotted fever vaccine will be withdrawn from production at the Rocky Mountain Laboratory at the close of the current season. The tick canoratory at the close of the current season. The tick vaccine was the first developed against Rocky Mountain spotted fever but has been superseded by the chick embryo type similar to that used for vaccination against typhus. The tick vaccine will, however, be available from the Rocky Mountain Laboratory as long as the present supply may last.

State Health Officers, particularly in those States in which Rocky Mountain spotted fever vaccine has been used extensively, may wish to inform physicians of any change which may be necessary next year in their procedure for securing spotted fever vaccine.

Sincerely yours, Leonard A. Schule Surgeon General U. S. Public Health Service FOR PATIENTS WITH

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The Iournal

of the

South Carolina Medical Association

VOLUME XLIV

December, 1948

Number 12

*On Friendliness

REGINALD FITZ, M.D. Boston

Seventy-two years ago my grandfather, Dr. Edward H. Clarke of Boston, listed the age of the most important medical societies in the United States. He credited the New Jersey State Medical Society as having come into existence in 1766, the Massachusetts Medical Society in 1781, and the Medical Society of South Carolina in 1789. Anyone willing to concede that the South Carolina Medical Association, whose centennial we celebrate today, sprang from the loins of that other society "instituted at Charleston, December 24, 1789," must feel, as do I, that indeed I have been paid a high compliment in being invited to play a part at a meeting which brings together representatives of two of the three senior medical organizations in the country. For this compliment I am deeply grateful.

Shortly after the Massachusetts Medical Society was born, one of its earliest acts was to devise a seal; a committee produced for the purpose what was termed a "Figure of Aesculapius, in his proper Habit, pointing to a wounded Hart, nipping the Herb proper for his Cure, with the Motto: Natura duce." While it must be admitted that the resultant picture as viewed from an artistic standpoint is neither beautiful nor well drawn, yet as a symbol of idealism it is, perhaps, more praiseworthy.

A few years later when the Medical Society of South Carolina wrote its constitution and by-laws, the matter of a seal also seemed important. Theirs was described as follows: "In the center is a representation of the temple of Health, within whose portals is seen an arm extending a laurel wreath; the three steps leading to it are engraved with the words, "Diligentia," "Scientia," "Benevolentia," and upon the cornice of the dome is seen the motto, "Sacrum Saluti."

One gathers that the Puritan conscience of New England wished to emphasize for the benefit of posterity the value of conservatism in medical thinking,

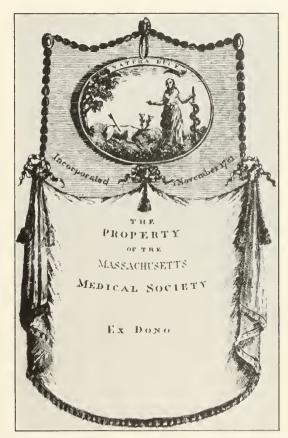


Fig. 1.—The book-plate of the Massachusetts Medical Society showing Aesculapius "in his proper Habit pointing to a wounded Hart." No replica can be found of the Seal of the Medical Society of South Carolina.

while the less inhibited South Carolinians sensed at once the need of a scientific approach to medical problems as they arose, the desirability for ceaseless diligence in solving them and, above all, the value of

Presented at the Centennial Meeting of the South Carolina Medical Association held in Charleston, May 13, 1948.

friendliness in making for a happy and well-functioning profession. These three pillars — Conservatism, Science and Diligence, blended with Friendliness—have been strong enough, it seems to me, to support for a hundred and sixty years a peculiarly sympathetic understanding of each other's interests between doctors in two such geographically distant areas as South Carolina and Massachusetts. This, I hope, will continue.

One has only to recall Benjamin Waterhouse and David Ramsay in the early days to perceive the possible significance of what I have in mind.

In the spring of 1799, Dr. Waterhouse in Cambridge happened to receive from England a copy of Dr. Jenner's pamphlet, "An Inquiry into the Causes and Effects of the Variolae Vaccinae;" this, of course, describes better than anyone else has been able to "what renders the cow-pox virus so extremely singular is, that the person who has been thus affected is forever secure from the infection of the small-pox."

He studied this article with greatest zeal and at last determined to attempt to repeat Jenner's observations. From friends abroad he managed to have sent him some of the virus, and he first vaccinated his four children, then their nursery maid, and finally three servants. They all had satisfactory takes; but in order to control such experiments properly, he sent his oldest son Daniel, who was five years old, to a near-by small-pox hospital, inoculated him with matter from a patient who had active small-pox and placed him in the bed with another patient ill with the disease. Young Daniel developed no signs of trouble; Dr. Waterhouse remarked that a single such observation was worth a thousand arguments; in this fashion vaccination was introduced into the United States.

In attempting to promote vaccination in New England, Dr. Waterhouse at once butted his head against the stone wall of conservatism. His colleagues ridiculed the thought that anything but harm could result from a cow's disease produced in man, and they accused him of charlatanism and of almost everything else which was undesirable. Fortunately, he found an important ally in Dr. Ramsay. It is not known how well these two physicians knew each other, or, indeed, if they knew each other at all; It is a fact, however, that in January 1802, Dr. Waterhouse shipped a supply of virus to Charleston; that in February Dr. Ramsay vaccinated his son Nathaniel successfully and from this source—so he says—thousands of his fellow eitizens were henceforward rendered immune. Apparently, had it not been for the diligence and scientific talents of Dr. Ramsay, the general importance of vaccination might have been overlooked in North America for many years to come; as it was, its use spread quickly from the South over the rest of the country.

Dr. Ramsay must have been a man of rare persuasiveness. In Boston, Dr. Waterhouse was driven to hire subjects to submit to vaccination in order that he could keep a live strain of virus at hand, while in Charleston, according to the fee table employed in 1804, Dr. Ramsay had so convinced the population of the importance of the procedure that the operation was valued at the price of nine dollars a scar.

Nearly half a century later a second example of the friendly medical relationship between Boston and Charleston occurred, 1850 marked the date of publication in Boston of Lemuel Shattuck's famous monograph, "Report of a General Plan for the Promotion of Public and Personal Health." Mr. Shattuck was not a physician but a schoolmaster; a visionary who thought that good health was a national asset which belonged to the people and which should be cultivated. He proposed that the State should enter the practice of preventive medicine by studying health through aecurate vital statistics, by rational public health legislation, and by research. His ideas seemed too radical and were at first received coldly by conservative Massachusetts doctors. Little by little the sense of his thoughts became apparent so that in 1861 the Massaehusetts Medical Society petitioned the Great and General Court for the establishment of a State Board of Health, and in 1869 the petition was finally heeded. Other states followed suit; in 1877, at a meeting in Charleston, the South Carolina Medical Association drew up a memorial asking their legislature for a State Board of Health. It took the doctors here only one year to accomplish what had taken nineteen in Massaehusetts, and the results were much better as the Medical Association was designated the Board, thus leaving the administration of public health in the hands of the medical profession, where it properly belonged. This was an example of another idea developed conservatively and against opposition in Massachusetts but carried forward more diligently and scientifically in South Carolina.

In recent times, when matters of medical economics grew to seem important, the mutually sympathetic thinking of South Carolina and Massachusetts became evident for a third time. Four years ago, in 1944, the South Carolina Medical Association postulated a significant program for the eare of its people. The gist of it can be described in a few words; cooperation and understanding among all groups of individuals concerned with providing and improving medical care is essential; adequate medical care for those unable to pay for it must be provided through the use of public funds; voluntary plans to meet the costs of medical eare must be formulated and should include all possible individuals and groups of individuals; hospital facilities must be made available in areas needing them; medical practice and education must in no way fall under political domination or control. Two years later the Massachusetts Medical Society, using different words, expressed almost an identical philosophy: adequate medical eare must be available to everyone regardless of their ability to pay for it; any successful medical eare plan must depend on cooperation between the public, the doctors rendering the professional care, and the agencies administering it; the provision of medical care for those unable to provide it for themselves is the responsibility of the local or state government the costs of medical care to those who can afford to pay for it must be met by direct payment or by voluntary insurance for such expenses. And the physicians of both South Carolina and Massachusetts agreed that better public health education is vitally important so that everyone may learn to utilize the knowledge which modern medicine has to offer in the prevention, recognition and management of illness.

I have come to the conclusion that the cement which has bound together, for so many years, Science. Diligence and Conservatism in the medical thinking of South Carolina and Massachusetts must have for its most potent ingredient the element of Friendliness. This, I believe, still is powerful. The personality of a few ambassadors of good will who have lived in Massachusetts seems to have left there some of the characteristic warmth of South Carolina and to have brought back the knowledge that people in our chilly climate actually look upon life and medieine much as do they and their friends in the South. The influence of these ambassadors has proved invaluable.

Dr. Jacob Rhett Motte graduated from Harvard College in 1832 and during his junior year meticulously kept a diary of his college doings. Evidently he was a delightful youngster, brought up in Charleston, well connected in South Carolina on both sides of his family, blessed with pleasing manners, good looks, and a gay heart. He found life at Harvard much to his taste—and no wonder since everyone appeared to like him. He studied reasonably hard, danced through a pair of new pumps during a single Boston season, met everyone worth meeting, was made to feel like a son by President and Mrs. Quincy, like a brother by their two daughters, and he felt equally at home in all the great houses on Beacon Hill. He was one of the few undergraduates of his day to own a velocipede and on this contraption was able to travel between Cambridge and Boston more rapidly and cheaply than by other means of transport so that he spent a good deal of time investigating the latter metropolis. He found the young ladies fairly attractive although on the whole they compared unfavorably with the ones he remembered as decorating Wentworth Street amid gardens and balconies. He left behind a multitude of friends; he closed his diary with the words, "Three years shall I study medicine in Boston! Well, I shall endeavor to forget where I shall be, and not know whether in Boston or Charleston by my exclusive devotedness to my studies."

Something occurred to change his plans so that he conducted these devoted studies at the Medical College of South Carolina; Harvard's loss, no doubt, was the College's gain. This, however, is beside the point; the point is that he founded in Boston an everlasting sense of South Carolina friendliness and took away

from it a pleasant loyalty to its peculiar customs. He proved a magnificent ambassador.



Fig. 2.—A view of Charleston in the time of Dr. Motte and the early days of the South Carolina Medical Association.

Dressed in more modern costume, there have been a procession of others like him who have since followed in his footsteps: William Weston and George Benet of Columbia, Joseph White of Greenville, and John Boone of Charleston, to mention a few of recent times.

Thirty-eight years ago Dr. Weston became a Bostonian in a single month by taking a summer course in pediatrics there. It was under the supervision of Professor Thomas Rotch and was conducted by such junior instructors as John L. Morse, Maynard Ladd, and Henry I. Bowditch all of which sounds inconsequential. Yet in this brief time he managed to make a host of friends: perhaps he told unforgettable stories of the South, demonstrated the proper ritual on warm summer evenings of julep making, or perhaps he merely brought to Boston great kindliness in the art of caring for sick ehildren. In any event he quickly became adopted as a favorite son: later his Bostonianism made it possible for delegates from the South Carolina Medical Association to become well acquainted with delegates from the Massachusetts Medical Society at meetings of the American Medical Association. More than once they have supported, together measures which he believed were best for the common good-a difficult feat of strategy had he not known the Massachusetts men almost as well as he knew the delegates from his own state and had he not acquired the confidence of both groups.

Dr. Benet came to Boston at about the same time but stayed longer—a shy boy when he arrived to occupy lodgings off Harvard Square near the College in Cambridge. He, like Dr. Motte and Dr. Weston, proved a powerful ambassador, soon planting in the midst of Boston another fertile crop of South Carolina good-will and bringing back, in return for this, surgical ideas from Dr. Harvey Cushing, medical ideas from Dr. Henry Christian, and affectionate memories of all his friends.

This is the way it has gone for over a century; the Harvard Medical School will always be grateful for the students who have come from South Carolina, bringing with them ambition and high ideals, leaving behind friendliness, and taking away to use as they

saw fit, whatever Boston medicine had to offer—even including a Henry Asbury Christian prize. This particular honor is awarded to the man in the graduating class of the Harvard Medical School who appears to offer greatest promise of future success;—this year Lloyd Hollingsworth Smith, Jr. of Easley received it.

I am sure that friendliness among doctors deserves emphasis. It will always be important. Even in these days when one can read what medical men are doing and thinking in all parts of the world, the impression received from meeting them face to face is much more vivid than is any impression obtained through print. Moreover, misunderstandings are better avoided, new knowledge is more quickly disseminated, and greater progress is made by talk between friends than by any more formal means.

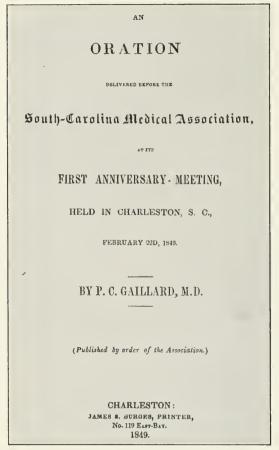


Fig. 3.—Title page of Dr. Gaillard's Oration delivered at the First Anniversary Meeting of the South Carolina Medical Association.

Therefore, I trust that during the next hundred years the members of the South Carolina Medical Association will maintain their longstanding ties with colleagues in Massachusetts, While their traditional approach to the problems of medicine by Diligence and Science may come to make New England Conservatism seem old-fashioned and cumbersome, yet Friendliness, I am confident, can continue to bind their varied interests closely together. The sentiments which Dr. Peter Gaillard expressed in his oration at the First Anniversary Meeting of the South Carolina Medical Association held in Charleston, February 22, 1849, are as memorable ninety-nine years later at the Hundredth Anniversary Meeting as when they were first spoken: May the love of learning, the constant striving after something better and more elevated. ever continue to activate not only this Association but also our profession the world over.



Symposium

Modern Management of Certain Chronic Diseases of Middle Life

SOME ASPECTS OF THE SURGERY OF
HYPERTENSION
William H. Bridgers, M.D.
Columbia, S. C.

It has been stated that cardiovascular and renal disease cause two hundred thousand deaths a year. This is a far greater number than that due to cancer. Of the estimated fifty percent of these patients having hypertension, approximately sixty percent die of cardiac failure and about forty percent die as a result of cerebrovascular accidents or uremia.

The great majority of the total cases of hypertensive disease are so-called essential hypertension. During the past sixteen years a great deal has been done to prove that many of these patients may be benefitted by various operative procedures on the sympathetic nervous system.

During the next few minutes I would like to discuss some aspects of the surgery of hypertension.

In considering a hypertensive patient for sympathectomy a number of factors have to be determined. Since it is known that conditions such as, polycystic kidneys, glomerulonephritis, pyelonephritis, neoplasm, and some endocrine disorders, can produce hypertension, various studies should be carried out to help eliminate such causative agents. It is of importance to carry out tests designed to demonstrate the possibility of reversal of the hypertensive state as well as a careful workup of heart and kidney functions.

Ordinarily the preoperative studies can be carried out during the first four days of hospitalization. Such a study includes a careful history and physical examination including a neurological with special reference to ophthalmoscopic study; x-ray of chest with cardiac measurements; electrocardiograph; intravenous pyelogram; PSP excretion: Mosenthal; blood chemistry for NPN and urea nitrogen determination; urea elearance; routine blood and urine examination; sodium amytal depressor test; as well as, frequent observation of pulse and blood presure.

The eyeground changes are usually classified into four groups: Group I consists of arteriolar constriction only. Group II shows tortuosity and A. V. nicking. Group III consists of an associated retinitis, evidenced by the presence of exudates or hemorrhages or both. Group IV shows more advanced changes with an associated papilloedema.

There is no test or group of tests which can accurately predict lowering of blood pressure following sympathectomy, however following such a study as outlined, poor operative risks may be found as well

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as patients who probably would not be benefitted by operation.

Probably the best results following sympathectomy occur in patients under forty years of age, especially women, with a drop in blood pressure to near normal levels with bedrest, a similar drop in blood pressure in response to depressor tests, and in patients with little evidence of organic change. There are many exceptions however, to this criterion. Distressing subjective symptoms are seriously considered since it is well known that symptomatic improvement is marked following sympathectomy whether the blood pressure is lowered or not.

Some of the contraindications to operation are as follows:

Serious renal failure; serious heart discase, particularly coronary occlusion, cardiac decompensation and heart block; chronic glomerulonephritis; frank encephalopathy with increased intracranial pressure; and, a fixed blood pressure.

Patients over fifty years of age with a diastolic pressure over one hundred and forty mm. are considered poor operative risks.

Most of the operative procedures used at the present time consist of removal of the greater and lesser splanchnic nerves together with a partial or total sympathectic ganglionectomy. The Smithwick procedure consists of removal of the sympathetic ganglionic chain from the 8th thoracic through the 2nd lumbar ganglion along with the greater and lesser splanchnic nerves. A flank incision is used with resection of portions of the 11th and 12th ribs. The exposure is transdiaphragmatic and extrapleural. It is a bilateral operation, usually done in two stages 10 days apart. Some surgeons remove the entire lumbar chain, and during the past few years, some are removing the entire sympathetic chain from the stellate through the lumbar ganglia.

The kidney and adrenal gland can be inspected at operation. On occasion a small benign adenoma of the adrenal is found, the removal of which does not affect the hypertension. On the other hand, if an unexpected adrenal tumor, such as a pheochromocytoma, is found, its removal can be expected to cure the hypertensive state.

Occasionally in the extrapleural approach, the pleura is torn; this is easily handled by positive pressure given by the anesthetist and aspiration of a catheter placed in the depth of the operative field during closure. The catheter is removed following aspiration.

Postoperatively the patients frequently have some discomfort due to pleural pain, transient parasthesiae and abdominal distension. If there is a marked postural

hypotension following operation, the use of elastic stockings and an abdominal binder improve these symptoms. Regardless, it is usually accommodated for within several months. Elevation of the head of the bed during the postoperative period seems to decrease the tendency towards postural hypotension. Cold hands and nose are compensatory phenomena and tend to diminish after some months.

In the great majority of patients who have headaches preoperatively there is a dramatic improvement. Such improvement is difficult to understand since relief from headaches frequently occurs following thoracolumbar sympathectomy even when the blood pressure is not lowered to a significant degree. Obviously the lowering of blood pressure is not the direct cause of this relief.

Other subjective improvement noted postoperatively, such as the relief from dizziness, apprehension, nervousness, agitation, and irritability is striking in the majority of patients. Many of these patients are able to resume an occupation which was not possible before operation.

The systolic and diastolic blood pressure is frequently lowered postoperatively. The extent of drop varies greatly. A good number of the operated cases show a stabilization of blood pressure to near normal levels. A gradual rise in blood pressure over a period of years can be expected in a number of cases. Further denervation could be considered in some, depending on the results of various studies as mentioned previously. It is felt that the evaluation of the degree of the drop in blood pressure should not be made until 6 months postoperatively.

Decrease in the size of a previously enlarged heart is noted on frequent occasions following sympathectomy. A similar improvement is seen in the electrocardiographs of many patients who had significant changes in the EKG tracings before operation. On occasion a return to normal has been observed.

Improvement in the eyeground changes in the form of subsiding hemorrhages and papilloedema has been gratifying in the majority of postoperative cases.

Albumin and red blood cells in the urine have disappeared following operation on occasions.

Recently there has been more evidence, obtained from the study of large series of postoperative cases over a period of years, to confirm the contention that adequate operation will give longer life expectancy in some cases.

In conclusion, it should be pointed out, that in cases of essential hypertension, meeting the requirements as outlined, lumbodorsal sympathectomy and splanchnicectomy seems to be a treatment of choice, in view of the marked symptomatic relief; frequent improvement in abnormal eyeground changes and electrocardiograph abnormalities; diminution in the size of an enlarged heart; and, frequently lowered blood pressure.

CHRONIC PULMONARY DISEASE

Robert B. Stith, M.D.

Florence, S. C.

The medical management of chronic pulmonary disease has changed little except in a few specific instances in several years. In the short time allotted me I shall confine my remarks to the management of chronic suppurative lung disease. specifically bronchiectasis. In another paper this morning the surgical management of lung disease will be-has been covered. It is the scope of this paper to cover the medical management of those cases which for one reason or another are not amenable to surgical intervention. Rarely do patients with bronchiectasis who have passed beyond the age of 50 have sufficient reserve to warrant an operation. Advanced emphysema and fibrosis may present intollerable deficiencies of blood oxygenation to the heart and brain. Patients with chronic asthma have proved poor candidates for thoracic surgical procedures. Since only a small percentage of patients with bronchiectasis meet the indications for lung resection the remainder of these must be treated expectantly.

Modern diagnostic procedures reveal that bronchiectasis is much more common than was formerly believed. Among chronic pulmonary diseases it is probably exceeded in frequency only by tuberculosis. Until recently no specific therapeutic measures were available. Heretofore treatment afforded only symptomatic relief and did nothing to impede the development of new lesions. The introduction of newer methods of treatment not only provided a very definite plan of attack but has made it possible to dispel, to a great degree, the extreme pessimism which formerly prevailed both among physicians and patients concerning the prognosis in bronchiectasis. In the medical management of bronchiectasis three methods of approach are utilized-postural drainage, bronchoscopic aspiration, and chemotherapy. The evacuation of bronchial secretions is the keystone in the treatment of bronchiectasis whether it be preventive, therapeutic, pre-operative, or post-operative. The proper application of postural drainage takes into consideration the site of the disease, the slope of the draining bronchi, the age, physical condition, and cooperativeness of the patient. Upper lobe bronchietasis drains best with the patient in the upright (Fowler's) position. Midzone disease drains best in the supine position, the diseased side uppermost. Lower lobe bronchiectasis requires the patient to bend over the side of the bed at the hips, the elbows resting on a low cushioned stool which supports a catch basin. The patient is urged to cough and expectorate in this position. Bronchoscopic aspiration is indicated if postural treatment cannot be carried out or requires supplementation. Bronchial lavage with medicated solutions has not gained popularity. The value of iodized oil instillations for therapeutie purposes is also debatable.

CHEMOTHERAPY: Logically a rational therapy must be based on possibly complete elimination of these potentially chronic infections. It is true that until recently little could be done to accomplish this aim. However, with the introduction of powerful antibacterial substances, especially antibotics, the long awaited opportunity is at hand. Over the past three years many investigators have found that prolonged treatment with penicillin and streptomycin aerosol is of greater value in this field than any other medicinal therapy thus far known. It is obvious that the use of an antibotic, regradless of how administered, cannot reverse permanent pathologic lesions, and that the therapeutic effect can, at best, accomplish only a temporary subsiding or arrest of the infectious process. However, an entirely different situation is found in patients who do not have such irreversible conditions, even though the existing bronchopulmonary infection often is of severe character. Here, complete recovery, or at least prolonged arrest of the infection after termination of treatment is the rule, especially, if the duration of illness has not been longer than several months or a few years. Relapses are mild in character and are easily controlled by a short new course with penicillin aerosol. The beneficial effect is alike in children and adults whenever permanent lesions can be ruled out and penicillin-sensitive organisms are the pathogenic ones. Six weeks of systematic treatment with daily doses of 200,000 or 400,000 units of penicillin will prove in most of these milder cases an efficient and rational way to overwhelm the bacterial invaders. Continuation of treatment with gradually decreasing doses for two to six months, will be required to assure more definite arrest of the infection and prevent early relapses.

A patient who presents such symptoms as persistent or recurrent productive cough following bronchopneumonia, influenza, and the like and in whom tuberculosis, malignancy, and other serious conditions can be ruled out most probably suffers from chronic pyogenic pulmonary infection. Sputum examination which in such conditions usually reveals the predominance of penicillin sensitive organisms should be done routinely before the first treatment. However, if for any reason this proves impossible, the prompt and complete disappearance of cough and bronchorrhea under penicillin aerosol treatment is sufficient clinical evidence that penicillin-susceptible bacteria had been responsible agents. Although lipiodol studies are advocated in every non-tuberculous patient with persistent respiratory symptoms it will be found that prompt and lasting elimination of bronchopulmonary infection by penicillin aerosol can almost be considered as a therapeutic test for ruling out demonstrable frank bronchiectasis.

It has been sufficiently established that high blood levels or penicillin can be obtained by way of inhalation. However, penicillin aerosol is, by intent, a topical therapy, the concentration of the therapeutic agent at the site of infection and not in the blood being its chief advantage. The method of administration is as follows:

A glass nebulizer, either the vaponefrin or DeVibliss No. 40, is connected by means of rubber tubing to an oxygen tank equipped with a reducing valve flow meter. 4 to 6 liters of oxygen through the nebulizer produces a fine mist. A "Y" tube inserted into the tubing between the reducing valve and the nebulizer allows the oxygen to escape and not pass through the nebulizer except when closed during inspiration thus the loss of the drug is reduced to a minimum. Any source of air pressure is adequate. The ordinary familiar inexpensive automobile hand or foot pump has proved very convenient and efficient for patients who were unwilling or financially unable to use oxygen. Children too young to use the nebulizer directly are treated by means of one of the head tents now commercially available. A head tent can also be improvised by means of a wooden or metal frame covered by transparent plastic sheet material. Here, too, a hand pump handled by the childs attendant can replace oxygen. The tent is placed over the child and the nebulizer containing the required amount of penicillin solution connected with the tent which is then filled with penicillin mist. An adequate supply of fresh air can be assured by allowing some air to enter the tent from the bottom.

It has been found that it is easier and much more simple to use the triturate tablets of penicillin than that furnished in vials. These provide a fresh supply for each treatment. One or more tablets each containing 50,000 units of crystaline G-penincillin are put into the nebulizer and 1 cc distilled water added. Although 4 tablets will dissolve in this amount of water it is recommended that for more than two tablets at least 1.5 cc should be used since highly concentrated solutions occasionally disagree with the patient. A single treatment following this method takes from 10 to 15 minutes.

Where penicillin and streptomycin are combined 0.5 to 1 gram of streptomycin and 200,000 units of penicillin are mixed in 20 cc of isotonic sodium chloride solution. Each cc of this will contain 25 to 50 mg of streptomycin and 10,000 units of penicillin and can be nebulized at the rate of about 1 cc per minute and during the course of a day patients can nebulize 20 to 30 cc without difficulty. Combining these drugs does not impair the antibacterial activity of either.

What is to be expected of patients with chronic respiratory infections who are treated with penicillin aerosol or a combination of penicillin and streptomycin? Defervescence, lessening of toxicity, diminution in amount of daily sputum, loss of its foul character, rapid disappearance of the penicillin susceptible organisms, improvement in the patients appetite and gain in weight are uniformly observed. It is most helpful in control and prevention of phenmonitis which recurs in many patients with bronchiectasis. Results are considered satisfactory when the daily

volume of sputum is reduced 75% or more. Olsen of Rochester reports a long series of cases in which more than half of the non-surgical cases obtained a 75% reduction. Of 20 patients treated with combined penicillin-streptomycin aerosols 18 obtained a satisfactory result. In most instances failure to respond to penicillin aerosol therapy was due to the presence of gram negative bacteria in the sputum and it is in these cases where the addition of streptomycin is advocated.

THE SURGICAL TREATMENT OF CHRONIC PULMONARY DISEASES

David Wilson, M. D.

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In any discussion of the surgical treatment of chronic pulmonary diseases I think we should consider four diseases: bronchiectasis, lung abscesses, tuberculosis and asthma.

During the past ten years much of the fatalism which previously dominated clinicians' thinking in respect to chronic pulmonary diseases has disappeared.

The surgical treatment of such chronic diseases as bronchiectasis, lung abscesses and pulmonary tuberculosis has become an every day occurrence. The mortality and morbidity rates have been greatly reduced. In 1938 the mortality for lobectomy for bronchiectasis was 15 to 20 percent. Today it is 1 to 3 percent. Today we recognize that the individual lobes of the lung may be divided into bronchial segments. Separation of these segments at operation permits the preservation of uninvolved segments in the same lobe. The lingua of the left upper lobe has long been treated in this manner. These diseased segments can usually be identified in the lobe at operation by permitting collapse of the lung to occur. When this is done the diseased segments stand out as nodular areas of lung tissue in contrast to normal, smooth atelectatic lung which is uniform in consistency. The inflammatory reaction along the diseased bronchi in bronchiectasis accounts for this variation in appearance. This is especially important in older people where preservation of normal lung is essential.

Unlike bronchicetasis, the mortality rate for patients with lung abscess is still too high. Dr. David Smith at Duke Hospital has collected the results of 2,166 cases from various clinics treated since 1936. With medical treatment the mortality rate was 34.7 percent and with surgical treatment the mortality was 32.7 percent. The lowest mortality was reported by Neuhof and Touroff who have advocated early operation, preferably before the end of six weeks. Nearly every author on lung abscess has emphasized the importance of early diagnosis and prompt treatment. After the abscess has existed three months, the chances of medical cure are slim and the sooner

operation is performed, the better. The type of operation performed for a lung abscess is important and is governed by the type of abscess and the age of the patient. Fusospirochetal abscesses can be safely treated by drainage. Non putrid pyogenic abscesses do poorly with drainage and should have a lobectomy. Abscesses due to foreign bodies, such as aspirated peanuts require lobectomy. In the older age group these rules may have to be revised since simple drainage is more easily performed with less risk than a lobectomy. In the older age groups an abscess associated with a malignancy must always be kept in mind.

In the field of pulmonary tuberculosis the introduction of the new chemotheropeutic agents and new plastic materials which are well tolerated when used within the human body has permitted the re-evaluation of an old operation in the treatment of pulmonary tuberculosis. I refer here to the plastic, lucite, which we have been using in conjunction with an extraplcural apicolysis to maintain a permanent collapse of a tuberculous cavity. This operation accomplishes essentially the same pulmonary collapse as a thoracoplasty but has a much lower operative mortality and avoids the chest deformity which accompanies the thoracoplasty. Operation is performed under local anaesthesia by resection of a short segment of rib, either anteriorly or posteriorly usually in the apical region.

The lung with the parietal pleura is dissected free from the chest wall and the space filled with sterile hollow lucite balls. Streptomycin is injected into the space and the incision closed tightly. This maintains the lung in a permanently collapsed state. This is the operation of choice in older people beyond the thoracoplasty age and is especially applicable in the treatment of patients with bilateral apical pulmonary cavities.

The surgical treatment of bronehial asthma is still in the experimental stage. We appreciate the presence of a major psychosomatic complex. It has been said that surgical treatment consists of excision of nerves whose function is partially known for a disease, the cause of which is not fully understood. From a physiological standpoint bronchial asthma should be amenable to surgical treatment. Bronchial constrictor fibers apparently run in both the sympathetic nerves and vagus nerves. Extirpation of either system or the posterior pulmonary plexus gives symptomatic relief in certain selected patients.

Carr and Chandler at the last meeting of the thoracic surgeons in St. Louis presented a small series of patients successfully treated by removal of the 2nd, 3rd, 4th and 5th thoracic sympathetic ganglia and Dr. Abbott at Emory University discussed a similar series treated by division of the vagus branches going to the bronchi. The most striking improvement in these patients is the increase in vital capacity, especially in patients with associated emphysema. This operation

at the present time is in a stage where sympathectomy for hypertension was about ten years ago. It may be the solution for treatment of a small number of patients with bronchial asthma.

MENOPAUSAL AND MID-LIFE DEPRESSIONS

PSYCHIATRIC MANAGEMENT

William P. Beckman, M. D. Columbia, S. C.

Mr. President, Members of the South Carolina Medieal Association, and guests, it is a pleasure to me to have this opportunity to appear on the program of this particular meeting of the Association.

The subject assigned to me is one of importance and calls for considerable attention on the part of physicians everywhere. The depressions occurring during the menopausal, or involution, period of life are serious illnesses and need early recognition and adequate treatment. The involution period has been set by some as being the period of 40 - 50 years in women and 45 - 55 years in men. Others have set it as the period between 45 - 60 years.

In looking back over one's psychiatrie experience, perhaps no other psychosis stands out as well as involution melancholia. This illness caused the patient much suffering and disturbed the psychiatrist because of the fact that he seemed more or less helpless. The prognosis was not good and patients suffering with it remained in the hospital from eighteen months to several years and often spent the rest of their lives in the hospital. More recent advances in the field of psychiatry, however, have brought about quite a marked change in the treatment and prognosis of this psychosis.

In dealing with this subject the first thing we want to consider is the diagnosis. There are two main clinical pictures in this group. First, the pure involution melancholia, where the person is markedly depressed, agitated and entertains ideas of unworthiness and self-depreciation. There is no hope in this life nor in the life hereafter. To be as miserable as he, or she, must be due to having committed an unpardonable sin and God will no longer forgive. There is no way out except self-destruction and thoughts of this nature are entertained and often carried out. There is inability to sleep and loss of appetite, even refusing to eat.

The other pieture is complicated by the presence of delusions and is termed the paranoid type of the involution psychoses.

When these depressions occur toward the latter part of this age period, arteriosclerosis becomes a fairly frequent complication.

After the diagnosis has been established, the next question is—What do we have to offer in line of treatment? Within recent years much research has been carried on in the use of shock therapy in these depressions. It is now well established that electric

shock therapy is the most desirable treatment in these psychoses. This treatment is best carried out with the patient staying in the hospital. If not, he or she, is apt to terminate treatment as soon as improvement is felt but before the illness has been treated adequately. In our hospital the general rule is to consider twenty-one convulsions an adequate series.

In pure involution melancholia, the recovery rate is high. The literature reports vary from 60% to 90%. I regret that time did not allow an analysis of some of our records. If the patient responds satisfactorily, it is now possible to get a recovery in from three to four months, as compared to the poor prognosis in years past.

The percentage of recovery tends to be lower in those cases where delusions complicate the picture. Often, however, the patient is able to return home. This type is apt to require more treatment.

Where arteriosclerosis complicates the picture, but there is no demonstrable dementia, the outlook for recovery is fairly good, but the tendency to relapse is greater.

With reference to further management it must be remembered that in depression there is always the danger of self-destruction and care must be taken to do everything possible to prevent it from happening. Restlessness and sleeplessness will have to be combatted with drugs until they are controlled by shock therapy. The same is true with reference to maintaining nutrition. Shock therapy soon brings about an improvement but before this the patient must be urged to eat or even fed forcefully (tube feeding).

In summarizing, then, I wish to say that when it has been established that you are dealing with a depression of middle age, or of the involution period, the best treatment to be offered at the present time is electric shock therapy. This treatment is best carried out with the patient staying in the hospital and the results are very gratifying. There are cases that are resistive to the above type of treatment. Certain selected eases of this group can be benefitted by brain surgery, the operation being that of prefrontal leukotomy.

TREATMENT OF THE MENOPAUSE

John M. Fleming, M. D. Spartanburg, S. C.

The onset of the menopause is a gradual process unless castration is induced by surgery or radiotherapy. The physiological menopause is usually preceded by symptoms of preclimacteric which is of indefinite duration.

The average woman, above 30 years of age, anticipates the menopause with dread of losing her attractiveness. They likewise look forward to being harassed by such discomforts as hot flashes, sweats, headaches, poor eyesight and so forth. Many of these fears are increased by their physician who, instead of allaying their fears, gives them injections of Estrogens

and sends them on their way to tell their friends that they have seen Dr. X and they are in the change of life and must report to his office three times a week for Estrogen injections.

In treating the elimacteric age, it is necessary to separate these patients into the true menopausal group and psychoneurotic. T. E. Hasting has said—"One nervous woman can give rise to more diverse, undiagnosed and undiagnosable complaints than a whole pathological ward." This we all agree. And then is this patient ehronically ill—from a gynecological standpoint she is. Women above 40 years that have any irregularity of the menstrual period, assume they are pregnant—if menses are absent. To these patients, this is a calamity, and they have described the situation to me as being "just irritable and mad as hell at their husbands." This patient is chronically ill as there is abnormal personality changes.

In the married woman, either the presence or lack of a family may be equally disturbing. They realize that the last chance of reproduction has passed. With the woman who desires a child, or the woman who fears pregnancy at this late date after having reared a family, it may disturb their mental tranquillity. The childless woman who has not made adequate adjustment or the devoted mother, who with uncompensated grief sees her children leaving home to be married or seeking their stations in life, feels that her care rendered to her offsprings is unappreciated. Then she often resorts to self-pity which, we all know, has many ramifications.

Then what are the true symptoms of hypogonadism as manifested in women that are reaching physiological menopause?

I use physiological menopause in contrast to artificially inducted menopause, and the symptoms are objective and subjective—

Objective Symptoms Arc:

Menstrual Disorders

- 1. irregularity
- 2. scantness of flow
- 3. decreased duration
- 4. amenorrhea
- 5. metorrhagia
- 6. menorrhagia

Hypogonadal Obesity

- Deposit of fat over trochanters and adipose enlargemen tof Breast.
- 2. atrophy of genitalia
- 3. loss of genital and axillary hair.

Subjective Symptoms:

- Nervousness—manifested by feeling of nervous tension—(They feel something awful is going to happen but don't know what it is)
- Excitability—respond to ordinary stimuli in an exaggerated manner.
- 3. Irritability—These people are hard to please, impatient with their friends and family. They are simply hard to get along with.

- 4. Headaches—Various types of headaches but occipito-cervical is most characteristic.
- 5. Depression-or just blues.
- A large majority of these patients complain of sleeping poorly.

Circulatory Symptoms:

- 1. Hot Flashes
- 2. Tachycardia
- 3. Vertigo
- 4. Tinnitus
- 5. Cold hands and feet
- 6. Hypotension

General Symptoms:

- 1. Lassitude and fatigability
- 2. Constipation
- 3. Vague pains

I will not discuss the mental disturbances that occur in the climacteric. This will be discussed by Dr. Beckman. But the true menopausal syndrome only occurs in 15 to 20% of women. The symptoms will be most stormy in the nervous, neurotic, unbalanced woman—who has had numerous gyneeological operations—Suspensions, Ovarian Resections, etc. These are the women who land up in an Institution and must be put under the care of a competent Psychiatrist. The well poised and stable individual can be treated adequately by the family physician—who must be understanding, patient, re-assuring and convincing. Treatment consists of non-specific and specific—

Non-specific treatment of the menopause should consist of a description of the situation. The patient should be told that if the symptoms do not increase, very little treatment will be necessary and certainly no hormonal treatment such as injections, of which the laity is fully aware, will be needed. If the patient is overweight, she should be placed on a detailed, mild reducing diet. The fats and carbohydrates should be restricted. The patient should weigh herself once a week. Sufficient exercise, preferably walking, should be indulged in.

Dexedrine may be given to decrease the appetite, and I have found that this drug also gives the asthenie patient a sense of well being. Frequent measures to relieve constipation should be instituted. For the mild flushes and sweats which annoy the patient mostly at night, one half grain of Phenobarbital before retiring is usually prescribed. Occasionally one quarter grain may be used before each meal.

I believe each patient must be regulated to the dose that does not produce sleepiness during the daytime. Some patients have a greater tolerance for Phenobarbital than others. In my practice I find that ¼ grain—three times a day—before meals is sufficient to take care of most patients with mild symptoms.

Specific or Replacement Therapy-

During the last ten years, replacement therapy has changed a great deal. Campbell, Ayers and others have definitely shown that Estrogen given in large injectable doses have eertain carcinogenic stimulation that is manifested in carcinoma of the uterus and breast. The reports that are available at the present

time clearly show that the patient with carcinoma of the breast—if devoid of Estrogen—the chances for arresting the growth are increased. It is thought by some that with high Estrogen titer, the patient will be more likely to develop fibroid tumors. Certainly the fibroids grow more rapidly if the Estrogen content of the blood is increased by injections of Estrogens. We have all seen women that have by some means avoided the operating table with large fibroid;—when these women reach the physiological menopause, the tumors rapidly retrogress.

There are hundreds of Estrogen products on the market at the present and each detail man that comes along has the best. They still have the injectable Estrogens and are attempting to unload them on the Physician. Gynecologists agree that there is no place in the treatment of the menopause with injectable estrogens.

By proper medication, it is usually possible to abolish rapidly the flushes to relieve digestive disturbances and, in some cases, lessen the arthritic pains. Usually there is feeling of well being, and increases in physical vigor, but rarely an increase in libido is noted.

Sometimes I have seen blood pressure markedly reduced, but I believe this is due to the Phenobarbital.

In my practice, I use the natural Estrogens, by mouth only. The natural Estrogen is put out by a number of reputable Pharmaceutical Houses. These preparations come in .65 mg.—1.25 and 2.5 mgs. tablets.

An arbitrary classification of symptoms, as classified in my practice, are *mild*, *moderate severe* and *severe*.

The mild cases are only treated by use of Phenobarbital—usually ¼ grain twice a day and .65 mgs. of natural Esrogens by mouth. The mild cases I usually give 30 tablets of natural Esrogens. I always have the patient return in two weeks in order to evaluate the amount of Phenobarbital given. With some patients, ¼ gr. of Phenobarbital will cause drowsiness.

With some cases, we have to increase the Phenobarbital, others we must decrease. The amount of Estrogens given is usually constant for the first 30 days—depending on how much relief the patient gets. If the hot flashes are not improved, we increase the Estrogens to 1.25 mgs. nightly and up to 2.5 mgs.

The moderate severe cases are started off with 2.5 mgs. of Estrogens daily with Phenobarbital a gr. ½ t.i.d. and the dose of each is varied depending on the needs of the patient.

The severe cases are handled no differently from the mild and moderate severe cases except the amount of sedation is increased and the Estrogens are also increased. But these are the cases that end up with involution melancholia and is only an exaggeration of the menopausal syndrome and has supposedly the same etiology.

CONCLUSION

- 1. All women that come to our offices, complaining of multiple blazon of symptoms similar to those of the climacteric, are not in the menopause. The psychoneurotic and psychotic women—in spite of the fact they are in climacteric period of life—Estrogens and the treatment outlined above have no effect.
- 2. The patient should have the physiology of the menopause explained to her and reassured that it is a normal process and always keep in mind that the symptoms may be more likely due to other causes—such as domestic, or economic worries. And to tell such women that they are beginning the change is the easy way—but the wrong way out.
- 3. The use of simple Psychotherapeutic procedure—small doses of Phenobarbital and oral Estrogens—have been most satisfactory in my hands.
- 4. One word of caution—some people are sensative to Phenobarbital and occasionally they develop a skin rash—even if only minute doses are used.

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SOME ASPECTS OF CHRONIC ORTHOPEDIC DISEASE

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The dramatic increase in the number and proportion of the elderly in our population during the past few decades requires that the average physician have fundamental knowledge of the diseases of senescence. The recent war and advances in preventive medicine as well as therapy have done much to increase the average age of our patients.

With an overall increase in the average age of our *population*, rehabilitation of the aged after the various diseases and conditions to which they are subject becomes a matter of social importance and economic necessity.

One of the most common conditions treated in orthopedic practice is hypertrophic arthritis. This condition to some extent is a concomitant of senescence, and is due in large part to easily overlooked but frequently repeated injuries incident to the wear and tear of life. A curious phenomenon is the disproportion observed at times between radiological signs and *actual* symptoms. The most common locations of the condition with reference to the patient seeking medical advice are the cervical and lumbar spine, the hip and the knee joints. The majority of the cases have Heberden's nodes of the terminal phalangeal joints. In the average case, an increase in symptomatology follows overuse

either in weight-bearing or work. Pathological changes are confined to bone and cartilage rather than synovia and periarticular structures. A fairly full range of motion is usually maintained because inflammation is absent.

Symptoms depend largely on the location of the pathological process. The general health is unimpaired. Crepitus, which is palpable and sometimes audible, is usually present. When the process involves the cervical spine, pain frequently radiates into the arms and hip pathology often causes knee pain.

The physician is usually consulted because of *pain* and *fear*. Frequently the patient is so relieved by the explanation that *this* type of arthritis is merely a part of growing old that he is willing to live within the limitations it imposes with the knowledge that a life of invalidism does not lie ahead. With the adjustment to a lowered functional capacity, symptoms often abate. The family physician can often prevent or minimize the development of hypertrophic arthritis by showing the value of periodic health examinations in which early postural faults may be corrected, obesity prevented, and alterations in the character and amount of exercise planned.

Rest is the keynote of treatment. In cervical arthritis rest periods in recumbency to prevent muscle spasm, are used. It is preferable to use no pillow. At times a cervical collar is useful to promote rest and lessen muscle spasm by transferring some of the weight of the head directly to the shoulders. In the acute episode, traction in recumbency with a head halter frequently gives relief. In arthritis of the lumbar spine, the use of a firm bed and a surgical corset or brace frequently makes the symptoms less burdensome. Weight reduction is of paramount importance in arthritis of the knees, and the use of an ace bandage or elastic support gives symptomatic relief. Physiotherapy is of considerable importance and if a trained therapist is not available, simple equipment such as an electric pad and resistance coil heater are very effective. Various types of salicylate are useful, but aspirin has been found to be safest, most effective and least expensive.

One type of hypertrophic arthritis is so disabling as to require special mention. It is called malum coxae senilis. Fortunately many of these cases can be rehabilitated surgically.

It is frequently observed that persons lose statue due to an exaggeration of the normal dorsal kyphos as they grow older. This is due to varying degrees of senile osteoporosis which may reach an extreme degree. The origin of the deficiency lies usually in avitaminosis A and D and in senile disturbances in the gastrointestinal tract which interfers with absorption of calcium. These patients complain of radiating pain in the back and easy fatigue. X-rays reveal vertical flattening and wedging of the vertebrae with extreme

demineralization. Considerable improvement may be expected by administration of calcium, phosphorus and vitamin D. A Taylor type spine brace is helpful in preventing pain and minimizing deformity. Physiotherapy is also very useful. Senile osteoporosis is also partially, at least, the cause of the fractures which so frequently incapacitate the aged. Atrophy and thinning of the cortex allows the frequently recurrent pattern of fractures of the wrist, shoulder and hip in senescence.

In Colles' fracture, anotomical reduction with restoration of the normal relationship between the radial and ulnar styloid processes is of considerable importance from a cosmetic as well as a functional standpoint. The hand should be splinted in flexion and ulnar deviation and the fingers should be left entirely free throughout convalescence. Active motions of the shoulder as well as digits should be not only encouraged but actively supervised during convalescence. Failure to encourage shoulder motion in a Colles' fracture may result in a secondary limitation of shoulder function more disabling than the fracture itself.

The same amount of immobilization which, in a young person, may leave no residual disability, can cause permanent functional loss in an older person. This is exemplified in the frequently observed fracture just below the shoulder joint. A hanging cast is advised for this type of fracture. The emphasis, however, is to be placed on carly active exercise. While a fracture of the hip is frequently the last illness of an aged person, much has been done toward solving the problem. The majority of the cases can be treated by some form of internal fixation.

Even when non-union occurs (and it does occur more frequently than we would like), reconstruction is possible at times and through surgery the patient may again become self-sufficient.

It is important to remember that patients lose strength and their joints stiffen by disuse and that exercise should be prescribed precisely during convalescence. There is nothing more startling than the early and conspicuous atrophy of the thigh which takes place in the young athlete after a knee operation. This type of atrophy can be *prevented* in the *young* as well as the *old* by proper instruction in periodic exercise.

Nothing preserves a patient's strength and joint motion and stimulates his circulation better than having him up early. It happens too often that elderly patient's shoulders become limited in motion due to restriction of activity. In medical as well as surgical cases, the simple expedient of an overhead bar will often insure active participation of the patient in his own care and materially assist the nursing staff. Every

effort should be made to divorce the geriatric orthopedic patient from the bed as soon as possible in the interest of avoiding the complications so frequently observed as a result of bed rest in the aged.

REHABILITATION

by

G. S. T. Peeples, M.D.

State Board of Health, Columbia, S. C.

Rehabilitation in the sense that we are dealing with it today, means the restoration of an individual who has been chronically disabled, to that physical state where he can be of the most service and returned to gainful employment.

This literally means that we are trying to restore an individual to a self-respecting place in society, where he will no longer be a liability of, but rather an asset to society, a self-supporting tax-paying citizen. Therefore, the chief objective of rehabilitation is to prevent a cripple from becoming permanently disabled.

A great deal of attention has been centered on the disabled veteran as evidence of extensive disability in our population, whereas, in reality, disability among the civilian population is far greater. 19,000 amputations occurred among military personnel during World War II, against 120,000 major amputations among the civilian population. Only 1,500 men were blinded in military service, but 60,000 civilians lost their sight during this period. 265,000 men were permanently disabled in the war, but 1,250,000 civilians were permanently disabled by diseases and accidents in the corresponding four years. 23,000,000 persons in the United States are handicapped to some extent by disease, accidents and maladjustment, or war.

Rehabilitation pays economic dividends. In one hospital of the V. A. Medical Rehab. Service was given 130 chronic neurologic patients, many of whom had not been out of bed in 10 years. After nine months all but ten of the group manifested some worth while permanent improvement. All but a small percentage were made employable and capable of self care. Rehabilitation of this one group was considered to have saved the government over \$1,250,000.

Vocational Rehabilitation in 1944, working with 43,997 persons, increased the average yearly wage after rehabilitation from \$148.00 to \$1,768.00 per person. Many of these had been on public assistance at a cost of \$300 to \$500 annually. The cost of rehabilitation averaged \$293 per patient as a single rather than an annually recurring expenditure.

Medical Rehabilitation takes the patient from the bed to the job and is the dynamic Therapeutics of chronic disease. Although it is dependent on the skills of medical specialist, principles of rehabilitation are basic to the practice of medicine. One of its greatest problems is motivation, to encourage and convince the disabled persons that they can rehabilitate themselves. Such motivation can start at the time of the accident or onset of the crippling disease by allaying fears of the patient and giving courage, understanding and hope predicated on an accurate knowledge of what can be done.

It must be recognized that treatment of disease is only part of medical care and that equal emphasis must be given to treatment of the patient as an individual. Integrated programs of convalescent care, that stress activity as an adjunct to definitive treatment, can reduce the period of hospitalization, offset the deconditioning phenomena of rest in bed and prevent the harmful physiologic and psychologic sequelae which often result thru extended hospitalization.

Although it seems logical that medical rehabilitation should be an important service of every civilian hospital, there has been little attempt until recently to establish such programs. Rehabilitation in varying degrees is available in some tuberculosis, mental and other specialized hospitals, but little provision has been made for such dynamic care for more than 14 million persons who are patients in general hospitals each year.

The first comprehensive program of this sort in any community hospital in this country has been recently inaugurated at Bellevue Hospital in New York. The service has bed capacity for 80 patients and also operates in much the same manner as the X-Ray and laboratory departments as a service for other departments in the hospital. It treats both inpatients and outpatients on reference from the other services of the hospital.

Rehabilitation is a program which provides the doctor with a new and effective means of helping his physically or mentally handicapped patients to become self-sustaining, even though they cannot afford to pay for necessary treatment and care. Where eligibility and need are established, any type of medical or related care can be provided for the purpose of reducing or eliminating a vocational handicap.

Services are provided only on prescription. They include medical, psychiatric, and surgical examinations and treatment, hospitalization, convalescent care, dental care, nursing care, physical therapy, occupational therapy, speech therapy, prosthetic appliances, medical supplies, and drugs.

Every applicant is required to have a thorough medical examination before any services are provided. This examination usually is performed by his family physician, and the State agency pays for it. The examination also is used as an additional basis for vocational diagnosis.

In addition, vocational advice and counseling; any type of training from on-the-job instruction to a full college course; placement services; and follow-up to assure complete adjustment, are given as indicated. The purpose of the entire program is to assist the disabled to become self-sustaining men and women.

In every case, which is to receive any services, dependence is placed upon the doctor to discover, through proper examination and diagnosis the hidden tuberculosis, the latent syphilis, the unsuspected advanced carcinoma, kidney, liver, and cardiovascular diseases, which, if overlooked, would not only cause a complete waste of all rehabilitation efforts, but would later cost the patient his health or his life.

In spite of the time and money spent in educating the public on the ease with which chest x-rays, sero-logical tests for syphilis, and the periodic physical examination can bring about a far greater national health, there are still many otherwise intelligent persons to whom a blood test and a chest x-ray are things which even a sick person can just as well do without! This trend of thought is not a credit to our honorable medical profession for it is within their power and it is the Christian duty of the family doctor to correct this thinking.

Some physicians still think that once a person is paralyzed from his chest down that he is doomed to be bed-ridden and a charge on society the rest of his life. This, in spite of the fact that it has been proven hundreds of times that any person with a good mind and strong shoulders and arms, with the aid of braces can be taught by physical therapist to walk. Thus learning to walk he can learn a new vocation such as watch or radio repairing, photographic tinting, operating a ticket office at the theater, an elevator, teach music, conduct an orchestra, etc. Yes, a person with one arm and both legs amputated can still be trained for employment, be self-sustaning and self respecting.

There is a growing need for the development of scientific methods of measuring the work capacity and work tolerance, physical and mental, of handicapped persons, and the physician who has an interest in research of that nature may find this is a fascinating field of study, and one which will contribute greatly to the body of knowledge concerning rehabilitation of the handicapped.

There is a great dearth of specialized workshops and other facilities in which the severely handicapped can be given work-conditioning and other therapy concurrently with training. Active support of such undertakings in local communities by physicians would be most helpful. It is hoped that our new medical college will include in its plans provisions for physical and occupational therapy, workshops, and a cooperative working relationship with existing facilities such as The Murray Vocational School.

New drug therapy and other methods of treatment of epileptics is proving effective in many cases, and there is great need for greater interest in such activities by physicians everywhere; lack of especially trained physicians is the greatest deterrent in this field.

The foregoing examples are merely illustrative of the varied areas in which the interest and active participation of physicians would prove a boon to the growing array of disabled persons. The opportunities are many; the needs are great; the medical profession is needed in all cases; and in many is the sole hope.

-READ-

The National Health Program

A Summary

Page 396

TEN POINT PROGRAM

of the

SOUTH CAROLINA MEDICAL ASSOCIATION

1. Cooperation

To promote closer cooperation and better understanding between all groups and individuals concerned with providing and improving medical care for the people of South Carolina.

2. Political Control

To prevent political control or domination of medical practice or of medical education.

3. Study

To assemble and to amplify studies relative to the need and availability of medical care in each county of the state and in the state at large, and to publicize these findings.

To study all agencies in the state which are involved in the administration of medical care as to the type of work which they are doing and the effectiveness of the work which is being done.

To promote plans for providing or improving medical care where there is a need.

4. Care of Indigent

To prepare a uniform plan for the hospital care of the indigent, financed by public county funds, which may be used by individual counties or by groups of counties for their indigent sick, and to promote the general adoption of such a plan.

To promote the establishments of clinics in each county for the indigent ambulatory patients, financed by public county funds and operated or supervised by established hospitals or by the county medical society.

5. Hospital Insurance

To make voluntary hospital insurance available to all the people of the state and to promote the widespread purchase of such insurance.

6. Hospitals

To study the present availability and facilities of hospitals in the state and to promote the establishment of well-equipped and adequately-staffed hospitals in needy areas.

To establish through the State Medical Association standards for hospitals in South Carolina and to make public the names of those hospitals which meet these standards

7. Group Health Insurance

To promote the establishment of group health insurance plans in all industries, large and small, in South Carolina.

8. Standards for Insurance

To establish standards for insurance companies selling hospital or group health insurance in South Carolina and to publish the names of those who meet these standards.

9. Medical and Nursing Education

To promote the securing of adequate funds and facilities for the operation of the Medical College of the State of South Carolina.

To promote advancement in nursing education and nursing care in the state.

To promote the establishment of a loan fund whereby worthy young men and women of the state who are financially unable to meet the strain of a medical education may be able to secure aid.

10. Education of the Public

To acquaint the citizens of the state with regard to the agencies and facilities in the fields of medical care, public health, hospital and industrial insurance, and to encourage the people to use them on a much greater scale.



W. L. (BUCK) PRESSLY, M.D.

DUE WEST, S. C.

Recipient of General Practitioner's Award

American Medical Association

December 2, 1948

AN OPEN LETTER

Dr. W. L. Pressly, Due West, S. C. Dear Buck,

We were thrilled when we heard that you had been given the General Practitioner's Award of the American Medical Association. We were doubly thrilled when we learned that you had been elected on the first ballot. It made us feel mighty proud to know that one of our members had received this high distinction.

And yet, Buck, to be honest, we were not particularly surprised. You see, we know you for what you are; a hard working family physician who has never spared time or energy in serving your patients, an agressive leader who has always fought for what is right and forward-looking, a man of medicine who has always adhered to the high principles of our profession, a sincere and humble follower of our Master. And we knew that when physicians in other states became acquainted with your true worth, they would realize that you were cutitled to this recognition.

For the honor which you have brought to yourself and to our Association, for the life which you have lived and the deeds which you have done, and for your friendship through the years — we thank you. Our hope and prayer is that you and we can work and play and have our good times together for many years to come.

Your colleagues and friends,

The members of the
South Carolina Medical Association.

The Journal of the South Carolina Medical Association

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Please send in promptly notice of change of address, giving both old and new; always state whether the change is temporary or permanent. Original manuscripts, subject to approval hy the Editor and the Editorial Board, are desired for publication in the Journal. They should be typewritten, double spaced, on 8½ x 11 paper. References should be complete, and only such as relate directly to statements quoted in the paper. Illustrations will be used as funds permit, or as authors are willing to bear the necessary increase in cost. Short original articles are preferred to long reviews.

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DECEMBER, 1948

ON FRIENDLINESS

We wish to call particular attention to the article in this issue, "On Friendliness". It was the address which Dr. Reginald Fits of Boston delivered at the Association banquet during the celebration of our Centennial last May, and described the spirit of friendship which has existed through the years between the medical professions of Massachusetts and of South Carolina.

Friendliness—how the world needs such a dynamic force today. Friendliness—the only foe which can conquer hate and greed and war. Friendliness—of which the angels sang on that first Christmas morn, "And on earth peace, goodwill among men."

"HOLD THE LINE, PLEASE"

The setting is the office of Dr. Smith, practicing physician. The time—eleven a. m. on a busy morning. The telephone rings and in answer to the secretary's "Hello," a voice replies, "Dr. Jones would like to speak to Dr. Smith."

"Just a minute," the secretary answers. Placing the receiver on the desk, she interrupts Dr. Smith in the middle of an examination to give the message.

Dr. Smith excuses himself and pieks up the receiver.

"Hello."

"Is this Dr. Smith?"

"Yes."

"Hold the line, please, Dr. Jones wishes to speak to you."

One, two, five minutes pass as Dr. Jones' secretary relays the message to Dr. Jones who disengages himself from his patient and finally comes to the telephone to carry on a conversation which he instigated. All the while Dr. Smith sits and waits—far from patiently—and wonders who this fellow Jones thinks he is that he can keep somebody else dangling at the other end of a telephone line at will.

An hour later Dr. Smith is again summoned to the telephone.

"Dr. Black from Blackville is calling," his secretary announces.

"Hello."

"Is this Dr. Smith?"

"Yes."

"Hold the line, please, Dr. Black is ealling."

Five minutes, ten minutes pass. Finally, comes the voice of the operator from Blackville. "Dr. Black was ealling you but he has stepped out to the drug store, and I can't locate him. I'll have to call you back."

"You needn't bother," Dr. Smith mutters as he slams down the receiver. "I've got plenty to do without sitting here holding the phone while Black runs out to get a eoea-cola."

The moral to these stories might be: When you waste another man's money, you can pay it back; when you waste his time—it's gone.

CANCER FILMS

Moving pieture films dealing with caneer in its various forms are now available for showing by county medical societies. These may be obtained from the American Caneer Society. Information regarding them may be obtained from Dr. Jas. Young, Anderson, Chairman of the S. C. Caneer Commission, or from Mrs. Eunice Leonard, State Board of Health, Columbia.

THE NEW COMMITTEE ON MATERNAL WELFARE

The South Carolina Medical Association took another forward step in its care of the citizens of South Carolina, when it resumed the activities of the Committee on Maternal Welfare. The work of the committee during the prewar years was outstanding, and it gained recognition far beyond the boundries of our state. Dr. R. E. Seibels was chairman of the old committee, and he is a man of vision and of energy. He made the work of the committee a hobby. The maternal mortality rate dropped steadily and markedly. Prenatal clinies were established widely

throughout the state, seminars for doctors were held and doctors and laymen were aroused to the problems of child bearing, largely through the efforts and leadership of Dr. Seibels' committee.

The new committee has undertaken its task with earnestness of purpose. The fact that the committee was not completed until late in the year has been one unavoidable drawback. However, it hopes to be able to report some accomplishment at the state meeting in May.

The first objective of the committee is to study statistically and factually the maternal deaths as they occur. For this study to be of value the attending physician will have to cooperate—and cooperation is earnestly requested. This cooperation will be the filling out of a rather simple questionnaire, which will be sent him by Dr. Hilla Sheriff, secretary, of the committee. There are not many questions asked, nor many spaces to be filled in, but there is one large space in which the doctor is asked to describe the case in detail. These questionnaires will soon start going out—the first will deal with deaths which occurred early in the year. Please try to return them promptly.

The committee plans to study these reports carefully and to attempt to determine why the woman died, and what could have been done to save herearly prenatal care, better nutrition, a blood transfusion, craniotomy of a dead baby, instead of cesarean section on an infected mother, earlier administration of antibiotics, ctc. These studies will not be made in an attitude of criticism or censure, but purely in an effort to learn why 350 mothers die each year. The findings of the committee will be reported briefly to the reporting doctor if he requests it.

The committee plans an educational program as an important part of its work. In collaboration with the South Carolina Obstetrical and Gynecological Society, public meetings are being planned where county health officers or other interested groups request them. The society will furnish a speaker or speakers from its speakers' bureau, which is being organized. It is hoped that every county medical society will have at least one obstetrical meeting each year, with either a speaker of its own selection, or one from the speakers' bureau. Anyone wishing a speaker from the latter should send his request to Dr. Manly E. Hutchinson, 1412 Bull Street, Columbia.

A final phase of the work planned by the committee is to arrange for and to sponsor obstetrical and gynecological seminars, when it is requested to do so by medical groups in the state.

This committee is definitely yours, you members of the South Carolina Medical Association. It is willing to work, but if its work is to be effectual, it must have your cooperation.

> J. Decherd Guess, M. D. Chairman

THE NATIONAL COMMITTEE ON ALCOHOL HYGIENE

The Scientific Committee of The National Committee On Alcohol Hygiene, Inc. now plans, for the ensuing year, a three-pronged drive aimed at:

- (1) Practically educating and obtaining results in getting general hospitals to accept the fact that the alcoholic is a sick person, and to aid in providing medical help.
- (2) To integrate a training program for medical doctors as directors of community set-ups for alcoholism control.
- (3) In the field of prevention, to acquaint the senior high school and young college students with the medipsychological facts about alcohol, alcoholic beverages and the alcoholic.

The Scientific Committee of The National Committee On Alcohol Hygiene, Inc. reports that activity-projects for the ensuing year are to be directed along the following lines:

- (1) To acquaint teenagers, senior high school and young college students with the medical psychological facts about alcohol, alcoholic beverages, and the alcoholic.
- (2) To attempt to integrate a director-training program, through cooperation with the U.S.P.H.S., Division of Mental Hygiene, the School of Hygiene of the Johns Hopkins Hospital, and medical doctors interested in alcoholism from the medical point of view. Such a program would benefit community clinics, such as, The District of Columbia Alcohol Clinic and other centers who need or wish to head-up the staff with a director who is competent and experienced in this field.
- (3) To attempt to present medical facts to the general hospital about treatment for handling acute alcoholism and alcoholism in general, and to gain their cooperation in providing medical aid.

MEETING OF COUNCIL, OCTOBER 31, 1948, COLUMBIA, S. C.

Chairman, O. B. Mayer, called the meeting to order with the following members present: Drs. J. W. Chapman, C. R. F. Baker, J. C. Sease, W. W. Boyd, R. B. Durham, Roderick Macdonald, C. S. McCants, L. P. Thackston, J. P. Price, and Mr. M. L. Meadors. Meeting with the Council by invitation were Drs. A. W. Browning, W. Wyman King, and Decherd Guess.

Mr. Howard O'Brower, representing the Council on Medical Service of the American Medical Association, and Mr. E. B. Crawford, Executive Director of the Hospital Savings Plan of North Carolina, were presented and spoke on the subject of the establishment of a medical service plan and its method of operation. Following a full and free discussion of the subject it was moved by Thackston and passed unanimously,

that the Chairman of Council appoint a committee to formulate a plan for a medical service plan for South Carolina and to report back to Council at a meeting on January 16, 1949. Dr. Mayer appointed the following committee: J. D. Guess, Chairman, J. H. Stokes, W. W. King, and M. L. Meadors. The Treasurer was authorized to defray the expenses of the committee.

A communication was read from Dr. J. B. Youmans of Chicago with reference to the publication of a YEAR BOOK OF MEDICINE in magazine form which could be sent to physicians as a supplement to the state journal. Following discussion the Secretary was instructed to inform the members of the Association as to this proposed publication and to receive subscriptions on behalf of the members.

A resolution was adopted continuing the present Historical Committee with instructions to the Treasurer to defray necessary expense.

Following discussion with reference to the fee schedule of the Industrial Commission a resolution was adopted instructing the chairman to appoint a committee of five to meet with representatives of the Industrial Commission in an effort to revise the fee schedule and to bring it up to date.

Following a request from Dr. H. S. Gilmore, President of the State Health Council of South Carolina, for a contribution toward the work of the organization, a resolution was adopted instructing the Treasurer to pay an amount up to \$500.00, sufficient to carry on the work of the Health Council.

Dr. C. R. F. Baker, Councillor, brought to the attention of Council certain difficulties which had arisen between members of the profession in Kingstrec. This was received as information.

An invitation was read from the Bureau of Health Education of the American Medical Association to participate in radio broadcasts over NBC now being sponsored by the A. M. A. A resolution was adopted accepting the invitation and instructing the President and Secretary of the Association to make the necessary arrangements.

The question of attempting to secure special automobile licenses with the letters M. D. appearing thereon was discussed. It was decided to refer this matter to the House of Delegates.

The question of the annual licensing of physicians was also brought up for discussion and this matter was referred to the Legislative Committee for study and recommendations.

A request was received from the Bureau of Public Administration of the University of South Carolina for information relative to the Association to be published in a Directory of public and private agencies rendering services for state and local public officials. This matter was referred to Mr. M. L. Meadors for study and action.

A letter was read from the Woman's Auxiliary of the South Carolina Medical Association relative to a proposed bill to be submitted to the legislature for making diptheria immunization compulsory for all children before entering school. Council decided to refer this matter to the House of Delegates at its coming meeting.

Following a request from Mr. M. L. Meadors, Council authorized the formation of district public relations councils to be composed of the Councilor from each district as chairman, and one member from each constituent county society, such a member to be appointed by the Councillor.

Following a general discussion concerning naturopaths a special committee composed of J. H. Stokes, Chairman, Lawrence Thackston, Roderick Macdonald, W. W. King, A. W. Browning and M. L. Meadors, to study the problem and all its aspects and to make specific recommendations as to action which should be taken by the South Carolina Medical Association.

A communication was received from the editor of the South Carolina Magazine requesting the privilege of devoting an issue of that magazine to the work of the South Carolina Medical Association. The invitation was accepted and a committee composed of the president, the editor and the historian of the Association to collaborate on this project.

The Secretary presented information received from the Secretary of the American Medical Association relative to the South Carolina Medical Association being entitled to two delegates to the A. M. A. Since a state association is entitled to a delegate for each thousand members or fraction thereof, the South Carolina Medical Association now qualifies for two delegates. The second delegate is to be elected at the annual meeting in May and will begin his term of service January 1, 1950.

Adjournment.

J. P. Price, M. D.

Secretary

THE TEN POINT PROGRAM

M. L. MEADORS, DIRECTOR OF PUBLIC RELATIONS AND COUNSEL

STATE HEALTH COUNCIL ORGANIZED

On November 17th an important step was taken toward a better understanding between the public and the medical profession on matters of health and medical care in South Carolina. Ever since the Ten Point Program was instituted there has been under consideration, and for the past several months there has been active effort on the part of the Committee on Rural Health, toward organization of a State Health Council. Chief credit for the progress made and the accomplishment of the organization is due Dr. Harold S. Gilmore of Nichols, Chairman of the Committee. Other members of the Committee who assisted him ably were: Dr. A. W. Browning, Dr. M. J. Boggs and Dr. J. A. Hayne, Jr.

The idea of a State Health Council, of course, is not new. They already exist in several other states, and the plan adopted in South Carolina follows closely that of the Virginia State Health Council. At the present time in South Carolina, there are, according to our latest information, twelve county health councils, whose purpose and objectives are generally the same, on a local basis, as will be those of the State Health Council.

Following the first Statewide Health Conference, called by Dr. Gilmore's Committee in May of this year, and pursuant to a Resolution adopted at that time endorsing the idea of the Health Council, the Steering Committee of nine met in September and drew up a proposed plan of organization. This plan was presented to the meeting here on November 17th at the Columbia Hotel, which was attended by representatives of twenty-one organizations, state and local, in South Carolina. Dr. Cilmore presided and Mr. William W. Lowrance, Superintendent of the Tuomey Hospital of Sumter, representing the State Hospital Association, acted as Secretary.

The purpose and plan of the Council may best be grasped from the four general objectives stated in its Constitution:

- 1. To strengthen, through united support, a full health program for the state.
- 2. To serve as a clearing house on health and medical care problems and programs.
- 3. To assist in the elimination of duplication and overlapping of efforts, when practicable.
- To bring together local and statewide organizations, agencies and individuals to facilitate joint planning where needed, and for special joint efforts.

A number of specific goals related to the foregoing, and designed to aid in their accomplishment are also included.

At the meeting on Wednesday, November 17th, the proposed Constitution and By-Laws were taken up item by item and considered in detail. Opportunity was afforded every person present for the expression of opinion, and they took advantage of it. The meeting was marked by a lively interest on the part of those present, indicating their earnest belief in the importance of the business at hand.

The new organization will be known as the South Carolina Health Council. Its membership will be open to agencies and organizations whose functions are entirely concerned with health and medical care, and those which have indicated a continuing interest in these subjects. Provision is also made for individual memberships.

Following adoption of the Constitution and By-Laws, the organization was completed by the election of the following officers: Dr. H. S. Cilmore, Nichols, Chairman; Miss Catherine Edwards, Greenville, Principal, Elementary Schools, First Vice-Chairman; Mr. O. G. Dorn, Sumter, Representative of the South Carolina State Grange, Second Vice-Chairman; M. L. Meadors, Florence, Secretary; and Mr. R. L. Dougherty, Columbia, Representative of the State Hospital Association, Treasurer.

Members elected to serve on the Executive Committee were: Miss Isadora R. Poe, Greenville, President of the State Nurses Association; Miss Juanita H. Neely, Rock Hill, State Home Demonstration Agent; Mr. Thomas D. Wyatt, Spartanburg, Representative of the State Board of Pharmaey; Mr. E. H. Agnew, Anderson, Representative of the State Farm Bureau: Dr. C. L. Guyton, Columbia, Representative of the Hospital Division of the State Board of Health; Mr. W. W. Lowrance, Sumter, Superintendent, Tuomey Hospital; Mr. Earle R. Britton, Columbia, President. South Carolina Federation of Labor; Mr. W. G. Bunch, Charleston, Representative of the Charleston County Health Department; Mr. George A. Buchanan, Columbia, Vice-President, South Carolina Hospital Service Plan; and Dr. W. J. Snyder, Jr., Representative of the South Carolina Medical Association.

COUNCIL CONSIDERS PREPAYMENT PLAN

At the meeting of Council on October 31st, the matter of organization of a medical prepayment plan was taken up and considered at length. Mr. Howard O. Brower, from the staff of the AMA Council on Medical Service, was present to offer suggestions and information from that source, and Mr. E. B. Crawford, Chapel Hill, N. C., Executive Secretary of the Hospital Saving Association, Inc., of North Carolina, also at-

tended to present views based upon his experience in the management of the prepayment plan in his state.

Mr. Crawford's organization is a member of Assiciaated Medical Care Plans (AMCP), the organization set up about two years ago to establish standards and otherwise unify the policies of the prepayment plans in operation throughout the country.

After receiving the benefit of the suggestions of both these gentlemen, and discussing the matter freely, Council appointed a special committee, headed by Dr. J. D. Guess of Greenville, to make a further study and investigation and report at a subsequent meeting with recommendations as to the type of plan most adaptable for South Carolina. Council was favorably impressed with the North Carolina Plan, represented by Mr. Crawford, and the manner in which it is being operated, and the Committee was requested, in the course of its deliberations, to visit Chapel Hill and go into the matter further.

Other members of the Committee serving with Dr. Guess in this important work are: Dr. Howard Stokes, Florence; Dr. W. Wyman King, Batesburg; and M. L. Meadors, Florence.

It was apparent that Council intends to proceed definitely with the organization of a prepayment plan as soon as a decision is made as to the type and method of operation.

THE NATUROPATHS

It will be recalled that in the closing days of the 1948 session of the Legislature, a Resolution was passed directing the Board of Naturopathic Examiners to make a full investigation with respect to the licenses issued certain of their practitioners, and to report to the General Assembly next year on the opening day of the session. Considerable activity on the part of the Board has since been noted, and it is apparent that this body expects to be in position to report to the Legislature full compliance with its direction.

We have had numerous questions from time to time as to what further steps, if any, will be attempted on the part of the South Carolina Medical Association. This matter was presented to Council at its meeting on October 31st, and a special committee was appointed to look into the subject and present its recommendations to Council, at a subsequent meeting, as to any further action which may be considered desirable or necessary.

The matter is now under consideration and any activity in this respect during the legislative session of 1949 will be based upon the conclusions and directions emanating from the Council.

THE NATIONAL HEALTH PROGRAM A SUMMARY

On September 2, 1948, Mr. Oscar R. Ewing, Federal Security Administrator, released to the press a Report entitled "The Nations Health—A Ten-Year Program,"

Reference has previously been made in this column to the Report and to the deliberations of the National Health Assembly held in Washington last May, on which, to a large extent, the Report is based. It will be recalled that the National Health Assembly was arranged by Mr. Ewing, pursuant to the request of President Truman for a report on the state of the Nation's health.

The Report, while including such an evaluation, goes farther and outlines a Ten-Year Program for the accomplishment of a number of objectives which Mr. Ewing and his associates believe to be essential to the highest standards of health and medical care in the United States. The National Health Assembly brought together about 800 professional and community leaders, representing nearly every occupation and school of thought. The medical profession was of course represented.

The result of the election on November 2nd has added immensely to the importance of the Ewing Report. While, as stated, there has been reference to it briefly on previous occasions, we believe that now every member of the South Carolina Medical Association will want to know more about the details of the program which has been outlined. In all probability it is an accurate blueprint of the proposals which will be made for legislation by the new Congress, in line with announcements of the president during the campaign and since.

The following unbiased summary of the 186page Report presents the essential points of the program and is well-worth the time it will take to read it. Exact quotations from the Report are included, as indicated, and special emphasis is added in the form of bold-faced type to draw attention to points of particular interest to the medical profession. This summary appeared originally in the October issue of the Ohio State Medical Journal, and is reprinted here by permission:

FOREWORD

"'I would like to make it clear that I have weighed carefully every finding and recommendation of the Assembly. To the issue of health insurance, I have given particular time and thought. The Medical Care Section of the Assembly unanimously agreed that "the principle of contributory health insurance should be the basic method of financing medical care for the large majority of the American people". There was no agreement on the question of national health insurance and my recommendation of such a program must be clearly understood as in no way expressing the views of the Assembly. It took no position, one way or the other, on this question.

"'.... The arguments that have been made against national health insurance have been care-



"Aminophyllin may be given in the form of rectal suppositories (0.25 to 0.5 Gm.) or intravenously (0.24 Gm. in 50 cc. of fluid, 0.48 Gm. in 100 cc. of fluid), both for its diuretic effect and for its bronchodilating action, which relieves dyspnea."

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^{1.} Orgoin, E. S.: The Treatment of Congestive Heart Failure, North Carolino M. J. 8:125 (March) 1947.

^{*}Searle Aminophyllin contains at least 80% af onhydrous theophylline.

fully weighed and I still find myself compelled to recommend it. After all, we are dealing with human lives and human suffering and anguish. Every year, over 300,000 people die whom we have the knowledge and skills to save. This stark fact proves that the present system is inadequate. By and large, only the well-to-do and, to a certain extent, charity patients get satisfactory medical care. The in-between groups - other than the fairly small portion who are covered by voluntary insurance plans - are the ones desperately in need of better care. I see no possible way to provide funds needed for adequate medical services to these in-between groups, who constitute the vast majority of our people, except through a system of national health insurance.

"'The success of the National Health Assembly as a forum suggested to me the value of holding similar state and local assemblies throughout the country to exchange information and opinion, and to organize health work"'.

HEALTH OF THE NATION

"During the last generation, the United States steadily improved its health record, but the Nation, and the people, still suffer severe losses through sickness, disability, and death, much of which is unnecessary.

"Every year, the Nation loses 4,300,000 manyears of work through bad health.

"Every year, the Nation loses \$27,000,000,000 in national wealth through sickness, and partial and total disability.

"The record of Selective Service examinations during the war is widely known—5,000,000 men declared unfit physically or mentally for the armed services of their country.

"We know also that our armed forces create special demands for medical manpower; that a national emergency would throw an intense strain on our entire health system.

"But the record, good as it is, leaves plenty of room for improvement. Of more than, 3,800 deaths that occur daily in the United States, nearly 900—about 23 per cent—are preventable. Much of the sickness that cuts down the efficiency of the Nation's working force can also be prevented."

KIND OF SERVICES REQUIRED

"The types of services and care that must be made available to every person in the United States if we are to attain the highest level of national health are:

"Medical and dental care—Enough manpower that essential services should be available to everyone in a health center or hospital clinic, in offices, the home or wherever care is needed.

"A healthful community—Every town, city, rural area should be guarded by a well-staffed public health department.

"A community clinic—It will be particularly important for smaller towns and rural areas to have a publicly owned facility.

"A community hospital—A hospital large enough to care for all births and other ordinary hospital needs, so placed that no one in the county is more than an hour's easy travel from it.

"A district hospital—In urban centers to which local residents have direct access, and residents of surrounding communities may be referred.

"Special hospitals—For chronically ill, convalescent, etc.

"A medical center—At least one in every state, preferably associated with a medical school, where research would be carried on and medical personnel trained.

"Coordination—Organization of the previously mentioned units.

"A prepayment plan—A system of insurance should make it possible for everyone to have comprehensive care without worrying about meeting sudden bills out of current pay.

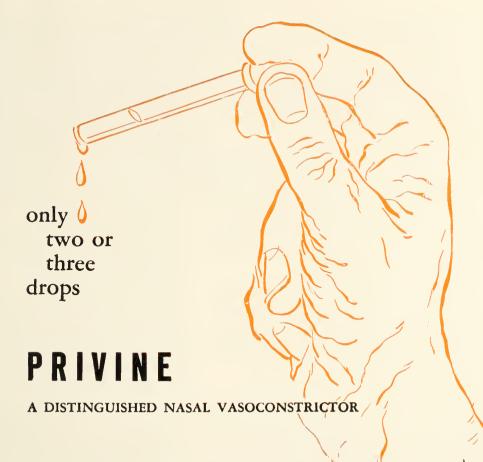
"In addition to our special efforts for the attainment of health, we must assume contemporaneous and parallel efforts to assure: (1) A steadily rising standard of living, assuring better nutrition, recreation, and other contributions to healthful living; (2) better educational systems—in number and quality; (3) increased benefits for the aged and permanently disabled so that their minimal essential economic needs are provided for; (4) adequate housing for the people of this Nation; and (5) increased understanding on the part of the people of benefits of scientific medicine and public health methods.

"It is important to point out certain limiting principles that must apply to any national program. Realizable health goals will vary, not only among individuals and groups, but among states and communities. No single set of health goals can be reached by all of the people and in all parts of the country in the next ten years. Plans for the attainment of health goals must be varied according to the relative needs and resources of various parts of the country.

"In the past our economy has measured the adequacy of health and medical services generally by the criterion, 'Is there enough to satisfy the purchasing power of the consumers?'

"We must measure our resources and services against the actual health and medical needs of all the people, without regard for their individual ability to pay.

"A scant 20 per cent of our people are able to afford all the medical care they need. About half our families—those with incomes of \$3,000 or less—find it hard, if not impossible, to pay for even routine medical care. Another 30 per cent of American families with incomes between \$3,000



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prolonged action The effect of each application of Privine provides two to six hours of nasal comfort, thus avoiding the inconvenience of frequent re-application.

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relatively free from systemic effects Although a sedative effect is occasionally noted in infants and young children—usually after gross overdosage—Privine is generally free of systemic effect. The absence of central nervous stimulation permits the use of Privine before retiring without interfering with restful sleep.

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and \$5,000 would have to make great sacrifices or go into debt to meet the costs of a severe or chronic illness.

"Success in our efforts for health will depend ultimately not only on Federal action but also on individual, community and state achievement, and upon the thorough and wholehearted cooperation of all interested groups and individuals."

MANPOWER

"The expansion of training schools, at an average rate of not less than 5 per cent per year in annual production, should accomplish the following by 1960: (1) Increase our present supply of 190,000 active physicians to 227,000; (2) increase our present supply of 75,000 dentists to 95,000; (3) increase our present supply of 318,000 nurses to 443,000; (4) increase our supply of other supporting personnel by comparable proportional amounts.

"The goal is to double the number of acceptable hospital beds as rapidly as possible, certainly within 15 years, and, at the least by 1960, to have added 600,000 beds to our hospitals, and build such additional health centers and auxiliary facilities as state-by-state surveys have shown to be necessary throughout the country."

FINANCING THE PROGRAM

"The value of all goods and services, including wages and salaries paid, amounted to \$230,000,000-000 in the United States last year. About 60,000.000 people were employed, so each one produced an average of about \$3,800 of the total. By applying this figure to days absent from work because of illness, total or partial disability, we can get a round idea of our national losses.

"The category called 'short-term sickness' includes all absences because of sickness or injury that last from one day to six months. During 1947 the total loss of time from these causes averaged six days per worker. At 1947 rates of production, short-term sickness cost the Nation at least \$5,000,000,000 in lost production and wages.

"Workers incapacitated because of chronic diseases, accidents or other causes cost \$11,000,000,000 in lost production and wages. The loss from partial disability is about the same.

"The nation thus lost \$27,000,000,000 during 1947 in potential production and wages through sickness, partial and total disability. We have not taken into account the losses occasioned by premature deaths. Retirement programs generally stipulate 65 as the age of retirement. Any death that occurs before this age may be considered premature. On this basis the total loss for 1947 was more than 27,000,000 life-years."

TO REDUCE LOSS

"Against these losses in production and wages, which last year amounted to more than 10 per cent of our national total, the Nation as a whole spent—from public and private funds—a trifle more than three per cent, or approximately \$8,500,000,000, for medical and health services.

"Of this, the local, state, and Federal governments expended \$1,962,000,000 for medical care and prevention, including the entire health program for veterans. Private individuals and organizations spent the rest—\$6,500,000,000.

"To make a beginning on reducing these human and material losses due to bad health, I have proposed a gradual expansion of health services and resources. This will involve, financially, an increase in spending by local, state, and Federal governments, and the institution of a prepaid system of government insurance.

"Medical care for the needy outside of hospital and other institutions at present costs the Nation about \$150,000,000 a year. Under the assumption that welfare agencies would pay premiums for the needy at the average per capita rate into the insurance funds, this total expenditure would probably be reduced by nearly 50 per cent to \$80,000,000, divided among Federal and state and local agencies — Probably some subsidies — about \$25,000,000 a year—would remain necessary in 1960, when insurance coverage may still be incomplete.

"Government expenditures for civilian health on this basis would represent about 1.6 per cent of a total personal income of \$250,000,000,000—a reasonable expectation for 1960—and would still constitute a negligible proportion of the amount the Nation loses every year through ill health."

FIRST HEALTH GOAL

"'To increase our supplies of medical manpower until there is enough everywhere in the country to satisfy the health and medical needs of all the people; to do this by expanding and establishing medical colleges, training schools and teaching hospitals until, by 1960, our annual production of medical manpower in all categories has increased by 40 to 50 per cent'.

"For normal times, an entirely realistic standard is based on levels of medical manpower already attained in our own country by the 12 states at the top of the ladder.

"The 12-state yardstick for physicians — the average of the top quarter of our states—is one for every 667 persons. On this basis, applied throughout the Nation, we will need 254,000 physicians by 1960. Our present prospects are for only 212,000 by that date.

"The 12-state yardstick for dentists is one dentist for every 1,400 persons. By this standard we will need 113,000 by 1960. Our prospects are for only 90,000.

"The 12-state yardstick for nurses, both professional and practical, is one for every 280 persons. By this standard we will need 566,000 nurses by

THE ATLANTA GRADUATE MEDICAL ASSEMBLY

ANNUAL MEETING — JANUARY 24-25-26, 1949

GUEST SPEAKERS

ANESTHESIOLOGY

Dr. John S. Lundy Mayo Clinic Rochester, Minn.

CANCER

Dr. Everett D. Sugarbaker University Hospital Columbus, Mo.

ENDOCRINOLOGY

Dr. E. C. Hamblen Duke University Durham, N. C.

GASTROENTEROLOGY

Dr. Henry L. Bockus University of Pennsylvania Philadelphia, Pa.

GYNECOLOGY

Dr. W. F. Mengert Southwestern University Dallas, Texas

MEDICINE

Dr. George C. Burch Tulane University New Orleans, La.

Dr. Walter Kempner Duke University Durham, N. C.

NEUROSURGERY

Dr. R. H. Smithwick Massachusetts General Hospital Boston, Mass.

OPHTHALMOLOGY

Dr. W. B. Clark Tulane University New Orleans, La.

PATHOLOGY

Dr. Morton McCutchen University of Pennsylvania Philadelphia, Pa.

PEDIATRICS

Dr. James Wilson University of Michigan Ann Arbor, Mich.

PSYCHIATRY

Dr. Wm. C. Menninger Menninger Clinic Topeka, Kansas

RADIOLOGY

Dr. Ross Golden Presbyterian Hospital New York, N. Y.

SURGERY

Dr. George Crile Cleveland Clinic Cleveland, Ohio

Dr. Lester Dragstedt University of Chicago Chicago, Ill.

Dr. O. H. Wangensteen University Hospital Minneapolis, Minn.

TUBERCULOSIS

Dr. Rufus F. Payne Battey Hospital Rome, Georgia

UROLOGY

Dr. Oswald S. Lowsley Brady Foundation New York, N. Y.

BIOCHEMISTRY

Dr. Konrad Bloch University of Chicago Chicago, Ill.

We would urge you to make hotel reservations immediately. Tell us your hotel needs, including arrival and leaving date, and your choice of the following hotels: Ansley Hotel, Hotel Atlantan, Henry Grady Hotel, Biltmore Hotel, Cox-Carlton Hotel, Imperial Hotel, Clermont Hotel, Piedmont Hotel and Robert Fulton Hotel. For further information or hotel reservation, write Mrs. S. R. Roberts, Executive Secretary, Atlanta Graduate Medical Assembly, 768 Juniper St., N. E., Atlanta, Ga. Registration fee of \$15.00 must accompany hotel reservation.

1960. Our present prospects are for only 403,000.

"Negroes comprise 10' per cent of the total population but produce only 2 per cent of the country's physicians.

"In 1947 the American Psychiatric Association reported only 4,500 certified psychiatrists. There is a need for at least 15,000.

"We have only about 3,500 pediatricians. We need at least three times that figure."

SECOND HEALTH GOAL

"'To assure that there are enough hospital beds of all kinds everywhere to meet the people's needs, and to finance hospitals so that they may give the highest quality services; to accomplish this by doubling the number of hospital beds, adding at least 600,000 by 1960; by building such auxiliary health and community centers as are needed, particularly in rural areas; and by uniting hospitals and centers into regional chains so that the most remote regions will have full access to modern and scientific medicine'.

"We have only about 900,000 acceptable hospital beds, outside of Federal hospitals, in the entire country, against established need for twice that number. At an average estimated cost of \$10,000 per hospital bed, the total cost of meeting our goal for hospitals is in the neighborhood of \$9,000,000,000.

"Under the Hospital Construction Act the Federal Government is contributing \$75,000,000 a year to build hospitals. If fully expended and matched with \$150,000,000 of local funds, this program will permit the Nation to build about one-eighth of its total needs by 1951. At this rate of building, we will meet 1946's needs in 1986—40 years too late. Private hospital construction cannot possibly fill the gap."

RECOMMENDATIONS ON SECOND GOAL

"'That the minimum Congressional appropriations for hospital construction for the next two years should be at least \$150,000,000 annually, which is double the present authorization of \$75,000,000 a year, plus such additional funds as are necessary to increase the Federal share of construction costs in areas of greatest need.

"'That as soon as possible, but certainly by the end of the first five years' operation of the amended Hospital Construction Act, Federal funds should be increased so as to finance the addition of 600,000 beds to our hospitals by 1960 and 900,000 beds within 15 years.

"'That the Federal government should provide up to 40 per cent of construction costs, beginning in 1949, and should encourage states to provide another 40 per cent to the end that improverished areas will have to finance only 20 per cent of original costs.

"'That the Federal government, beginning in 1949, underwrite up to 40 per cent of the main-

tenance cost of hospitals in selected areas of low per capita income for as long as such subsidies are needed.

"That all maintenance subsidies to hospitals be assured only on condition that professional personnel should be accepted as staff members, or as workers, in the underwritten hospitals without discrimination as to race, religion, or sex.

"'That Federal funds be made available to assist the states with administrative expenses under the Hospital Survey and Construction program."

THIRD HEALTH GOAL

"'To assure that every individual without regard to his economic status has full access to adequate medical services for the prevention of illness, the care and relief of sickness and the promotion of a high level of physical and mental health.'

"From the financial standpoint, the chief barriers to adequate care and service include: (1) The increased cost of modern scientific medical care; (2) the irregular and unpredictable occurrence of sickness and of the costs of medical care, when bills are paid out of pocket by the individual on a fee-for-service basis; and (3) the low incomes of many individuals and low income levels of many communities.

"The percentage of families in various income brackets during 1946 was as follows: Gross cash income of \$1,000 or less, 12.8 per cent; income \$1,000 to \$2,000, 15.4 per cent; income \$2,000 to \$3,000, 19.5 per cent; income \$3,000 to \$5,000, 31.4 per cent; over \$5,000, 20.9 per cent.

"In the light of these facts, it is clear that close to 70,000,000 people will have difficulty in providing adequate minimal care for themselves and their families. The difficulty will, of course, be greatest for those at the bottom of the scale. People with incomes above \$3,000 will probably be able to purchase minimal care.

"It is self-evident that there is no such thing as 'free' service. Health care, like everything else, has to be paid for by someone—by the individual, by taxes, private or institutional philanthropy or public subscription.

"There is a strong temptation to believe that the only solution of the problem lies in the bigger and better national income, better distributed throughout the population. The truth is that even this gradual accomplishment would not satisfy our national health needs. The people in the lower half of the income scale would still not be able to buy what they needed. Communities with lower per capita incomes would still not be able to support professional personnel and health facilities adequate to the needs of the people.

"The present methods of paying for medical care have served us well in achieving the present level of health, but the evidence cited in this re-

.1955. Looking Forward

\954.....1953...

"Much has been done, much remains to do, a way has been opened, and to the possibilities in the scientific development of medicine there seems to be no limit."

SIR WILLIAM OSLER, Aequanimitas

As yesterday's therapeutic triumph becomes today's routine procedure, physicians everywhere look forward to the revelations of the future. The perfection of today's resources and the expedition of those of tomorrow are the unremitting aims of Schering Corporation, manufacturers of hormones, chemotherapeutic agents, x-ray diagnostic media and other pharmaceutical products.

1949

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port shows that substantial further improvement demands new methods. First steps toward a better system of payment have been taken already under voluntary health insurance plans. For millions of people, these systems have made it possible to purchase a larger share of their health needs."

VOLUNTARY OR GOVERNMENT INSURANCE

"A satisfactory system of health insurance should provide: (1) That everyone should have ready access to adequate health and medical services; (2) that everyone should have the kind of services and all the services, he needs to promote better health; (3) that everyone should be able to obtain these without regard for the level of his personal income.

"Obviously, these criteria go far beyond the intent of any voluntary insurance plan. The objectives of such plans are confined, by and large, to making it easier for some people to meet some of the expenses of medical care, chiefly hospitalization.

"About 25,000,000 people—17 per cent of the population—have insurance for actual services in hospitals, usually only for a limited number of days.

"About 20,000,000 more people have policies for cash reimbursement of certain hospital bills, leaving part of the costs and services uninsured.

"Only about 3,500,000—less than three per cent of the population—have anything approximating comprehensive insurance protection that includes hospitalization and also doctors' care in office, home and hospital. In most cases, even these policies do not include such necessary items as dentistry, home nursing, expensive drugs, and such appliances as eyeglasses or hearing aids.

"In addition to these 3,500,000, some 16,000,000 or 17,000,000 people—nearly all of them included among those covered by hospital insurance—have protection against part of the costs of some physicians' services, usually restricted to hospitalized cases.

"Enrollment for hospitalization plus surgical benefits has spread mainly among industrial and commercial employees. About 60 per cent of all Blue Cross hospital plan members live in six rich industrial states that contain about 36 per cent of the total population. In the South and West, which have 43 per cent of the population, Blue Cross can count only about 17 per cent of its members. Its enrollment is predominantly among city people employed in commerce and industry. Less than three per cent of the rural population are subscribers.

"One factor that requires limitations on benefits is the flat-rate premium charged by nearly all voluntary insurance plans. The benefits will continue to be limited to what can be covered by the premiums paid in by the group.

"The cost of insurance—the flat-rate premium—undoubtedly places a ceiling on the number of persons who may be enrolled ultimately in voluntary insurance plans. It is extremely unlikely that any family of two or more persons with an income below \$1,000 will be able to pay an insurance premium of \$48 to \$72 a year. Most of the 22,000,000 people in families with incomes between \$1,000 and \$2,000 will be able, with hardship, to pay for some medical care. It should be pointed out, in this connection, that 70 per cent of all farm families had gross cash incomes in 1945 of less than \$2,000; and 42 per cent less than \$1,000.

"It is apparent that on a flat-rate basis, the voluntary insurance plans can never enroll any appreciable proportion of the 18,000,000 people in families with incomes below \$1,000 even in the limited hospitalization and surgeons' fees type of plan. The additional 22,000,000 in families with between \$1,000 and \$2,000 are almost all in the same positions. Probably 20,000,000 more in families with between \$2,000 and \$3,000 will remain outside the protection of the plans. If insurance benefits are broadened enough to provide reasonably adequate care, the premiums are even more out of reach for all this group and will be prohibitive to many who earn even more.

"This examination of the facts makes it clear that, at a maximum, only about half the families in the United States can afford even a moderately comprehensive health insurance plan, on a voluntary basis. The net result, then, would be to leave without adequate protection the very groups—those with income below \$3,000—whose plight the Nation needs most to remedy in order to raise the country's level of health.

"The limitation that lack of income places on expansion of voluntary insurance plans becomes even clearer when the coverage is matched with the per capita income levels of the various states. The spread of hospitalization insurance plans generally follows the same distribution pattern as the supply of doctors, hospitals, and other health services."

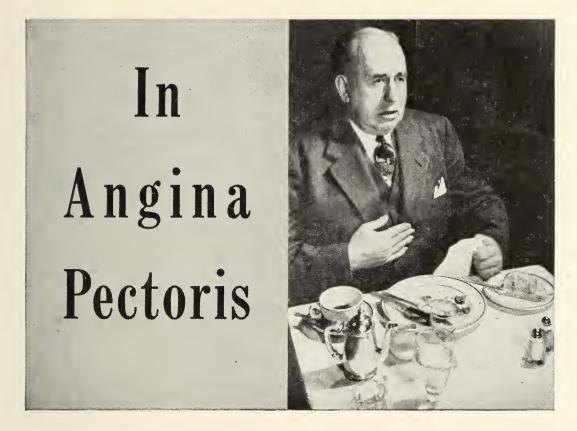
A WAY TO IMPROVE HEALTH

"There are many earnest people in the country who sincerely urge that we go ahead as we have in the past. They point out that the American health is equal to the best in the world; they feel that it is dangerous to make any basic change in the system that has produced this achievement.

"'I cannot accept this thesis. We can improve the Nation's health markedly. What was good enough 30 or 40 years ago, no longer is adequate.'"

A GOVERNMENT INSURANCE PROGRAM

"The prime objective of any plan for prepaid government insurance for medical services would



In Angina Pectoris the incapacitating symptoms frequently may be prevented by appropriately regulated administration of a vasodilator having a sustained effect. This type of medication may be indicated:

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- who suffers "indigestion" and "gas" after a heavy meal.
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be the improved health of the people. It would accomplish this objective in two ways: (1) By eliminating the financial barrier between any person and the services he needs to promote better health; and (2) by stimulating the development of more nearly adequate supplies of health resources and their equitable distribution throughout the country — doctors, nurses, hospitals, and other services—through the assurance that there will be a steady and effective demand for those health services.

"The logical sequence of events for accomplishing these ends would fall into this pattern of four phases:

"Phase One—Federal legislation to settle the basic policies of a system of government insurance to decide important details; and to provide for a three-year 'tooling-up' period before the date on which insurance benefits are made available.

"Phase Two—The tooling-up period, during which procedures would be worked out cooperatively by professional groups, localities, state, and Federal government; agreements arrived at with individuals and groups providing medical services; and the machinery for actual operations set up.

"Phase Three—Operations begin, services are provided up to the ceiling set by resources as they exist at the time.

"Phase Four—Expansion of services, as the accelerated increase and improved distribution of medical manpower and facilities lift the ceiling, until comprehensive services are available to everyone, everywhere in the country."

PHASE ONE—LEGISLATION

"The following 12 points indicate some of the major items for legislative action in a Federal law setting up a system of government insurance:

- "1. Objectives—The law would furnish policy guides to the public, provide for services and administration.
- "2. Coverage—The law would determine who would make prepayments and who would receive benefits. The coverage should be as broad as possible.
- "3. Premiums—It is fundamental that rates should be based on individual ability to pay—that is, be established as a percentage of earnings instead of as a flat rate.
- "4. Benefits—The benefits should be as comprehensive as possible with only such limitations as may be unavailable at the beginning. It should be clearly specified that the benefits are to be administered through Federal-state-local cooperation, with the major emphasis on administration at the state and local levels, so that the keynote is decentralization and local participation. It should be equally clear that payment for services

provided through physicians, dentists, nurses, laboratories, and hospitals would be made at rates and by methods mutually agreeable to them and the insurance system.

- "5. Guarantees to Insured Persons—The law should give explicit guarantees to insured persons and their dependents, including guarantees as to their rights to benefit solely by reason of their insurance; their right to make free choice—individually or in association with other insured persons—of physician, dentist, hospital, etc., and to make a change in that choice; their right to have their personal records kept confidential, to be protected against discrimination, to make complaints or appeals before appropriately constituted committees, and to have recourse to court review of administrative decisions which they believe are unfair.
- "6. Professional Freedoms—The law should give equally explicit guarantees to the members of the professions who provide services, including the right to participate in the plan or not, to act individually or in groups, to accept or reject patients who choose them, to retain control of professional aspects of professional service, to choose the method of payment for services rendered, to negotiate rates or amounts of payment and other matters through representatives of their own choosing, to make complaints or appeals before appropriately constituted committees, and to turn to the courts for review of administrative decisions. Such guarantees would preserve the essential freedoms of the professions and assure that they could not be 'regimented' by administrative officers.
- "7. Benefits for Rural People—The law should make special provisions to meet the needs of rural areas and the urban centers which serve them.
- "8. Education and Research—Support of professional education, postgraduate training, refresher courses and research should be provided.
- "9. State and Local Administration—Since the benefits would be provided in local areas under state plans, the law should state the minimum conditions to be observed by states and localities in administering the benefits on a decentralized basis.
- "10. Allocation of Funds—The law should clearly state the policies to be observed in allocating the insurance funds to the states.
- "11. Federal Administration—Administration of the national aspects of the program should be assigned to a small board of full-time members that included both professional and nonprofessional members, constituted so as to coordinate this insurance system with other social security and public health programs. The law should also establish an advisory council, with members

PROFESSIONAL MEN'S PROGRAM

A PLAN OF

INCOME PROTECTION WITH LIFETIME BENEFITS

Available to Eligible Members of the

MEDICAL - DENTAL - LEGAL Professions

Summary of Combined Benefits Provided in Policy Form UG 20N-477U Rider of United Benefit and PG 20N-745M Rider of Mutual Benefit

Monthly Benefit \$400.00

Double Monthly Benefits for Specified Travel Accidents \$800.00

Accidental Death Benefit Double Accidental Death Benefit for Specified Travel Accidents

\$10,000.00

\$20,000,00

ACCIDENT BENEFITS

Regu	llar Specified Travel
Indem	nity Accident Benefit
Total Disability, per month for LIFE, if incurred before age 60\$400	.00 \$800.00
Total Disability, per month for LIFE, if incurred after age 60 200	.00 400.00
Partial Disability, per month, for 3 months 160	.00 320.00
Physician's and Surgeon's Fees, for nondisabling injuries 50	50.00

SICKNESS BENEFITS

Confining sickness, per month for LIFE, if incurred before age 60___\$400.00

Confining sickness, per month for LIFE, if incurred after age 60____ 200.00

Nonconfining sickness incurred prior to age 59: Benefits payable up to age 60, per

month _____ 200.00

Thereafter - even for a LIFE-TIME—per month _____ 100.00 Nonconfining sickness incurred after age 59:

Benefits payable up to twelve full \$200.00

months, per month

Thereafter — even for a LIFETIME—per month

ADDITIONAL BENEFITS 100.00

Hospital Benefits (either sickness or accident), per month, up to 3

_ 200.00 Nurse's Benefits (if hospital confinement not required), either sickness or accident, up to 3 months _____ 200.00

ACCIDENTAL DEATH AND SPECIFIC LOSS BENEFITS

Regular Specified Travel Indemnity Accidental Death Accidental Death __\$10,000.00 \$20,000.00 Loss of Both Hands 10,000,00 20,000.00

Loss of Both Feet__ 10,000.00 20,000.00

Regular Specified Travel Indemnity Accidental Death Loss of Both Eyes__\$10,000.00 \$20,000.00 Loss of One Hand and One Foot ___ 10,000.00 20,000.00 Loss of Either Hand. Foot or Eye ____ 3,000.00 6.000.00

Features of this Plan

- Covers all accidents except aviation and and even covers specified air travel ac-
- Covers all illness except syphilis, veneral disease, insanity or mental infirmity.

 Wavier of Premium Provision.

No reduction in benefits because of occupational change of duties.

Nonaggregate—full limit of benefits paid for each disability.

- Double Limb Loss Benefits may be paid in one lump sum or in monthly install-ments for life provided total disability is incurred.
- Loss of one hand or one arm may be paid in one lump sum or in monthly install-ments for as long as five years, provided total disability is incurred.
- No Automatic Termination Age.

- Pays disability benefits regardless of whether disability is immediate.
- Pays disability benefits resulting from accidental bodily injury (the means or the act causing the injury is not a determining factor in the claim).
- The Companies offer eligible members of your profession policies which guarantee your right to renew except for these reasons only: Nonpayment of premiums; if the insured leaves the practice of the profession; or, if renewals are declined on all like policies issued to members of your profession in your state. This means that the Companies cannot decline to renew any individual policy without similarly de-clining to renew all like policies issued to members of your profession in your state.



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Tell me more about your Professional Policy	
Name	
Address	Ago

representing the interested public, consumer and professional groups, and with responsibility to advise the Federal board.

"12. Collections—Administration of the insurance plan, if linked with the existing system of national old-age and survivors insurance, could take advantage of existing machinery for collection of contributions, etc.".

PHASE TWO-TOOLING UP

"The three-year wait between enactment of legislation and the effective date of insurance benefits is essential to the program. The 'tooling-up' period would be employed: (1) To increase medical resources—doctors and hospitals, for example—and to encourage their better distribution, so as to provide the maximum services possible, beginning with the effective date; (2) to set up administrative operating machinery; and (3) to make certain insured persons and providers know their rights and are ready to exercise them."

PHASE THREE—OPERATIONS

"Beginning with the effective date insured persons and their dependents would obtain the health and medical services they need up to the capacity of the personnel and facilities existing at that time and limits of local availability.

"The number of persons covered in the United States by health insurance will depend on the terms of the basic legislation. If the law were enacted at once, and coverage made identical with that of the present old-age and survivors insurance system, benefits would be available to some 85,000,000 persons, counting insured workers and their dependents—a little more than 60 per cent of the population.

"When old-age and survivors insurance is expanded to cover groups not now included, a matching expansion of health insurance could cover between 120,000,000 and 130,000,000 people—nearly 90 per cent of the population.

"The ultimate goal is that every person should be eligible for insurance benefits."

SERVICES OF PHYSICIANS

"Health insurance should, from the beginning make the services of general practitioners of medicine generally available to all the insured. The plan should cover all the services which a legally qualified physician engaged in the general or family practice of medicine gives to his patients at his office, in the patient's home, at the hospital or clinic, or elsewhere. It should include preventive, diagnostic, and therapeutic treatment and care, periodic physical examinations, and the prescribing of necessary drugs and appliances.

"In metropolitan areas, all important specialists' services—including surgical and obstetrical services—probably would be available at the outset. Arrangements would be made for specialists and

consultants whenever necessary — for example, for obstetrics, pediatrics, major surgery, heart disease, cancer, and diseases of the eye, ear, nose and throat. In medium-sized and smaller towns and in rural areas, the insured would have access to some kinds of specialists close by, but would probably have to go to urban centers or depend on visiting experts for other highly specialized services."

SERVICES OF HOSPITALS

"General hospital services would be available to most insured persons, though in the first years some local deficiencies probably will exist. Hospitals would continue to be owned and managed by their present governing bodies, with full autonomy.

"There would have to be an extra charge if a private room were used, and since demand may exceed the capacity of hospitals until the building program is complete, some limitations on the number of days of care probably would be necessary.

"Dental Care—The extreme shortage of dental personnel makes it difficult to estimate the degree of availability under insurance. In many communities it should be possible to provide preventive dental care at least for children, and minimum continuing care for adults.

"Home Nursing—The availability of homenursing care will be uneven among different areas and may have to be limited to serious cases until the number of nurses increases."

COST OF INSURANCE

"For the basic services—physicians, hospitals, expensive prescribed medicines, and appliances—the insurance contributions in the first years after the program goes into effect would need to be raised from the nominal rate of the tooling-up period to about three per cent of annual earnings up to \$4,800 a year, probably divided between subscriber and employer.

"If the dental and home-nursing services start on a limited basis and develop gradually, it will be difficult to fix a contribution schedule that would not require several changes. The cost might amount to an additional 0.5 per cent of annual earnings at first and rise to about one per cent when these services become more adequate. The Federal government might consider paying for these services out of general revenue.

"Such financing would be sufficient to pay for the services needed by the insured population at rates fair to the practitioners and the institutions furnishing the services.

"These expenditures would represent new burdens on the economy or on the contributors only to a limited extent. They would be, for the most part, substitutes for expenditures already being made, without insurance, for the same kinds of services."

PHASE FOUR—EXPANSION

"With the beginning of operations under Government insurance, the effect of increased demand for services would make itself felt. Total and per capita costs for the insurance system as a whole will increase as services expand, but even when comprehensive services are available to everyone in the country, the contribution rate should not rise more than an additional one per cent—to a total of four per cent. The Federal government might use general revenues to supplement the contributions, as necessary, in the amounts equivalent to a fixed maximum percentage of contributions.

"One of the first effects would be an increase in the amount of recognized illness, an increase in the amount of service requested. This would be the stage when health insurance brings unrecognized, hidden, or neglected illness out into the open by making medical care more easily available.

"After a few years of this, we should expect a leveling-off and eventually an actual decline in the amount of serious illness. The amount of service may continue on a high level, but the proportion of preventive services could be expected to increase."

FOURTH HEALTH GOAL

"'To focus attention on mental health as a leading area for medical progress in the last half of this century; to promote research in the field of psychiatry and in the mental-emotional aspects of physical illness; to expand manpower and facilities for both preventive and curative work throughout the country; to accomplish these objectives through use of Federal research and other Federal assistance.'

"Over half of all patients in hospitals on any given day—some 600,000—are mental patients. Every year, 150,000 are committed to mental hospitals. Some 2,000,000 men were either rejected or discharged by the armed services because of neuropsychiatric disorders.

"From 30 to 50 per cent of all patients consulting doctors have complaints due at least in part to emotional disorders; 350,000 people each year are disabled from accidents; 60 per cent of these accidents stem partly from personality causes and nearly one-third of these have no other causes.

"Of more than 600,000 hospital beds occupied by the mentally ill, only about 400,000 meet minimum standards; moreover, there is an immediate need for 307,000 more beds for mentally ill patients. Our mental hospitals are severely understaffed and underfinanced. We have 600 psychiatric clinics for preventive work, against an immediate need for 1,400. We have only a handful of child guidance clinics. We need one mental health clinic for every 100,000 population."

FIFTH HEALTH GOAL

""To enable everyone in the Nation to enjoy a healthy, active and productive maturity, by controlling chronic diseases—the greatest single barrier to achievement of this goal—and by relieving the other physical, mental, and social problems of adult life."

"Half of the population is now over 30 years old, whereas in 1800 the median age was 16 for the entire country. We now have 10,000,000 people over 65 years old; by 1975, their number will probably have doubled to 20,000,000. More than a third of the Nation by that time will be 45 years old or more.

"This population trend will mean a further increase in chronic diseases unless we can make rapid progress toward bringing them under control. Older people are responsible for 70 per cent of all invalidism and partial disability. Of the total death toll of 1,402,000 in 1945, chronic diseases were responsible for 1,014,000. These deaths are divided as follows: Heart disease, 424,000; cancer 177,000; brain lesions 129,000; nephritis 83,000; tuberculosis 53,000; diabetes mellitus 35,000; and other chronic conditions 113,000.

SIXTH HEALTH GOAL

"'To rehabilitate the 250,000 men and women who become disabled through illness or injury every year so that they can be restored to the most nearly normal life and work of which they are individually capable.'"

"Each year about 250,000 men and women are so disabled by injury or disease that they become incapable of holding a job or of enjoying a normal life. Relatively few of this number suffer impairments so severe that they must always lead sheltered lives,"

SEVENTH HEALTH GOAL

"'To assure to every child in the country the utmost degree of health, a condition in which all his physical and mental powers are functioning at their best; to do this through a national plan that will build progressively toward complete medical care and social, psychological and health services for all children and mothers in child-birth.'"

"Each year 162,000 people under 20 die, although we have the knowledge and the skills to save the lives of nearly half of these."

EIGHTH HEALTH GOAL

"'Planning and action in every community and every state, directed toward providing the best possible health conditions for all their people, by assuring adequate local supply of needed services, and by organizing the local agencies of health—doctors, hospitals, public health departments, voluntary groups—into effective teamwork for the welfare of the entire community.'"

NINTH HEALTH GOAL

"'To establish everywhere local health units with full-time qualified staffs adequate to the needs of the population; to increase and improve the training of public health workers to the end that their numbers shall be doubled as rapidly as feasible.'"

"Our national deficiencies in the field of local public health departments are extreme:

"There are 40,000,000 people in some 1,200 counties either without a public health department or with departments that have only a part-time health officer.

"There are 96,000,000 people in the rest of the country served by inadequately staffed public health departments.

"Only 7,000,000 people in the entire country are

served by public health staffs that fully meet the minimum standards laid down by experts in this field.

"In 1946 approximately \$67,000,000 was spent for local health services throughout the Nation. Contributions were divided as follows: Communities 75 per cent; states 6 per cent; Federal government 18 per cent; and voluntary agencies 1 per cent.

"'I recommend, therefore, that the present system of Federal grants-in-aid through state health departments be expanded promptly, and that the Federal government appropriate \$250,000,000 for this purpose during the next five years. The appropriation should be increased promptly to \$40,000,000 annually and by 1953 should rise to \$58,000,000."

DEATHS

HORACE G. SMITHY

Dr. Horace G. Smithy, Jr., who performed one of the first successful heart valve operations in medical history, died in a Charleston hospital on October 29, at the age of 34, of rheumatic heart disease.

A native of Virginia, Dr. Smithy received his education at the University of Florida and the University of Virginia School of Medicine. He served his internship and residency at Roper Hospital and later joined the faculty of the Medical College of the State of South Carolina. He was assistant professor of surgery. Dr. Smithy gained nation-wide recognition early

Dr. Smithy gained nation-wide recognition early this year after he performed an operation on Miss Betty Lee Woolridge, 21 years old, of Canton, Ohio.

Dr. Smithy is survived by his parents, his widow and two daughters.

LONIE C. FLOYD

Dr. L. C. Floyd, physician and farmer, died at his home on November 2, after a lingering illness. He was 66 years of age.

Ďr. Floyd attended Clemson College and was graduated from the Medical College of the State of South Carolina (Class of 1910). He practiced his profession in Olanta until his health failed. He is survived by his widow and two sons, Dr. L. C. Floyd, Jr. and Kenneth D. Floyd, both of Florence.

JOHN P. DuPRE

Dr. John P. DuPre, 75, graduate of the Medical College of the State of South Carolina (1903), died at his home in Fountain Inn on November 15 after an extended illness.

A native of Charleston, Dr. DuPre began his practice in Spartanburg and then moved to Fountain Inn in 1913 where he lived until his death. He is survived by two sons and two daughters.

JOHN HENRY MILLER MADDEN

Dr. J. H. M. Madden, 35, died at the Columbia Hospital, November 2I, after an illness of five weeks. A native of Columbia, Dr. Madden secured his education at Clemson College (1935) and Johns Hopkins Medical School (1939). Following three years of hospital training at Duke Hospital he entered the U. S. Army where he served for five years, being discharged with the rank of a Major. Much of his time in service was spent in the China-Burma-India area. Upon return to civil life he located in Columbia as an associate to his brother Dr. L. Emmett Madden, in the field of internal medicine.

Dr. Madden is survived by his mother, three sisters (one of whom is Dr. Ethel Mae Madden, pediatrician of Columbia), and his brother.

CORRESPONDENCE

VETERANS ADMINISTRATION WASHINGTON 25, D. C.

April 27, 1948

Dr. Morris Fishbein Editor, The Journal of the American Medical Association 535 North Dearborn Street Chicago, Illinois

Dear Dr. Fishbein:

It has come to my attention that considerable misunderstanding has developed throughout the medical profession concerning the establishment of fees for medical services to be paid private physicians participating in the so called "Home Town Medical Care Program for Veterans." It has been contended that the Veterans Administration has arbitrarily established a Fee Schedule which represents the maximum amount which may be paid for any given service and which is, in effect, a National Fee Schedule. It has also been contended that the various State Medical Societies and other interest groups were not consulted when this Fee Schedule was adopted.

In order to clear up any misunderstanding regarding this matter, it is desired to emphasize that my predecessor, Dr. Paul R. Hawley, had no intention at any time of establishing a National Schedule of Fees, nor do I contemplate doing so. However, the Fee Schedules originally submitted by the various State Medical Societies, when the "Home Town Medical Care Program" was inaugurated, varied so widely in format, terminology, and fees for similar or identical services, that it was deemed advisable to establish a uniform Fee Sehedule Format and to set up tentative fees which could be used as a guide by the various State medical Societies when submitting their proposals for the furnishing of medical care to veterans.

This uniform Fec Schedule Format was formulated by the Professional Group of National Consultants to the Chief Medical Director. This Group, representing the various specialties in medicine and surgery, is composed of eminent physicians from all parts of the country. Tentative fees were set up in the format after a careful analysis of Pre-Paid Medical Care Plan, Workmen's Compensation and Insurance Fee Schedules, and also the Fee Schedules in effect in the various States having agreements with the Veterans Administration. As was to be expected, considerable variation occurred in the Fee Schedules reviewed.

The Professional Group of National Consultants made every effort to arrive at fees that were eonsidered to be within reasonable limits and which would, as nearly as possible, allow a uniform provisional fee schedule for use as a guide in facilitating and expediting the preparation of agreements between State Medical Societies and the Veterans Administration.

Further attempt was made to provide for elasticity in the charges for certain operations or other services which seemed to evoke more than average contention by listing the minimum and maximum amounts considered equitable. These items bear the notation "AA", which indicates that the fee for the given service is to be determined by arbitration and agreement between the Veterans Administration and the Mcdical Society concerned.

May I reiterate that the Veterans Administration Fee Schedule Format is in no sense to be construed as an arbitrary or National Fec Schedule. Furthermore, it is subject to periodic review and such modification as conditions may indicate.

If it meets with your approval, I would appreciate it very much if you could possibly arrange to publish this as an open letter in the Journal of the American Medical Association. I should like this to reach all of the physicians throughout the country, and I know of no better way to do it than through the Journal.

Very truly yours, /s/ Paul B. Magnuson PAUL B. MAGNUSON Chief Medical Director

WOMAN'S AUXILIARY SOUTH CAROLINA MEDICAL ASSOCIATION

President: Mrs. P. M. Temples

Publicity Secretary: Mrs. William H. Folk

PUBLIC RELATIONS AMBASSADORS

By William F. Doscher, Assistant Director,

Public Relations Dept., American Medical Association With your indulgence, I should like to speak for a few minutes on just three public relations points.

To me, the three points are the most important public relations challenges which face the Woman's Auxiliary—state by state—today and tomorrow.

First of these challenges was injected by Dr. Edward L. Bortz in his report to the House of Delegates of the AMA in Cleveland in January of this year.

Dr. Bortz pointed out—"The Auxiliary is now beginning to assume its rightful role. It represents probably our most effective instrument in the field of public relations, which, unfortunately, has been most neglected.

"As with all of us, the first need for the members of the Auxiliary is to be basically well-informed on the issues at stake. All of us should obtain the recent factual material which earries controversial issues faeing medicine today. The first responsibility is to have a clear conception of our job and how we mean to carry it on."

There is our number one point. Know and define the public relations issues confronting your state society, and relate these issues to your program activity.

Though easy to say, that's not easy to do.

Some folks don't recognize even certain obvious

public relations responsibilities.

Lester Perry, Executive Secretary of the Pennsylvania Medical Society reports the following true episode. He says, "A friend of mine was motoring through Texas last summer following an old farmer who was driving a dilapidated jalopy.

Delivered at annual conference of the Woman's Auxiliary to the American Médical Association, Chicago, on November 4, 1948.

"Presently the old Texan slowed down and pulled to the right of the road ahead, as though he were going to stop. Just as my friend stepped on the gas to pass the battered car made an abrupt left turn. You can gues what happened.

"When the cars were finally untangled, the jalopy could hardly be recognized. The old Texas farmer was unhurt but plenty angry. When he became abusive, my tourist friend reminded him that slowing down and pulling to the right did not indicate a left turn.

"Furthermore," he added, "you didn't even give me a signal."

"Signal, bunk" the old farmer yelled, as he pointed to a dirt road into which he had intended to turn, "Everybody knows I live right up there."

Well, of course, everybody does not know he lives right up there—just as everybody does not know what the Woman's Auxiliary is doing to help solve the health problems of this nation.

Folks in your community do not know what your public relations program is—how it works—how it benefits the community and the state and the nation. They won't know unless you tell them—not just once but over and over and over again.

Another way of saying it is that your statewide health objectives must be sold to the public by yon—through every publicity device in your command—newspapers, radio, bulletins, meetings, displays, talks, infiltration into other groups and every other media at your disposal. That is a public relations responsibility.

After consultation and agreement with your State Medical Society, your Auxiliary chooses its targets for the year and follows through in developing sound public relations activities. This is my second point.

From political results growing out of this week's election, the clarion call has sounded for us all. Our primary public relations target is selected for us.

It is exposing the dangers and evils of a system of socialized medicine as that system is practiced in Germany and England.

Medicine, in 1949, will be at the crossroads confronted with the imminent danger of surrendering to government control, or of organizing as it has never before organized to expose the nature of politicallycontrolled medicine, and to fight it.

Perhaps before the House of Delegates of AMA takes an official stand toward any health bill which is likely to be proposed next year, we can examine the facts.

The estimated cost of Oscar Ewing's proposed National Health Program which covers the creation of community hospitals, clinics, district hospitals, special hospitals, medical centers, free medical, surgical, dental and hospital care, home nursing and a host of other health and sociological activities, will be nine billion, nine hundred millions of dollars annually; this incidentally, in addition to the five billion, five hundred millions of dollars now contributed each year to government by labor and capital for social insurance. Such sum will be greater than the amount spent for national defense for 1948 and greater by billions of dollars than the entire national annual budget, including debt retirement of the United States government for the separate years from 1929 to 1939. The ultimate goal is 100% coverage for every man, woman and child. Guarantees of professional liberties are dictated in Mr. Ewing's bill of rights for the doctors, dentists and others, but under governmental domination and guidance of those liberties, rights and privi-leges are quickly reduced to political slavery. The government thus proposes to become the shepherd of our ills, of our souls; the custodians of every stomachache, ear irritation, appendix, gall bladder, pregnancy and a thousand and one other diseases and maladies. Born at 1-dead at 150-with government's prescription. Medicine's most deadly enemy today is not cancer or coronary; it can be pernicious political medicine.

The German people's experience with social insurance makes intriguing history. Introduced in 1883 by History, it became a powerful political weapon of Hitler's, who found that the German people were willing to sacrifice liberties for false security. You know, to your sorrow, the worsening plight of the English doctor today.

To develop awareness of the true dangers of compulsory health insurance takes imagination, time, and conscientious follow-through, but it will have to be done unless we are to weakly yield.

For public relations assignments, you need your best brains and talent, your most loyal workers. Nothing less will do, and I am certain that you can easily see why.

Dr. George A. Schenewerk, chairman of the on-itstoes public relations committee of the State Medical Association of Texas, in an article for the Texas Hospitals Magazine, made this statement: "No organization can hope to build a good, effective, public relations program if it begins at the 'public' stage. It must start at the policy stage and with the people who make up the organization.

Dr. Schenewerk here demonstrates the essential starting point of a public relations program. That is right within your own inner state executive councils.

Sitting down together with plenty of time to think, and with pencil and paper on the table in front of your group, armed with copies of your state program for the year, you are ready to discuss ways and means of selling it to the public. Your state Advisory Council members will appreciate an invitation to attend, and should have valuable contributions to make. Your state

public relations chairman will call the meeting to order and in general act as chairman. She should be well-briefed in advance, and know what she hopes the PR program will accomplish.

You then go through the following steps—each in great detail:

- 1. What specifically, are our state public relations goals?
- 2. Have we put them down in writing? Do our members know them?
- 3. What media are we to use to put them into best effect? Newspapers – radio – bulletins – meetings – talks or what? Which person is in charge of each of these media? Does she know how to do her job? Who can help her do her job?
- 4. What special functions have we in mind for the media people—a lunch for news reporters—for the radio people—joint relations meetings with cancer, heart, tuberculosis groups-letters to county medical society bulletin editors-talks with consumer groups and housewives – meetings with clerygmen, teachers, or workers' wives.

5. You discuss these steps carefully on a statewide 100 discuss these steps carefully on a statewide level—then take the time and trouble later to visit and go over them in a properly-revised form with your county public relations chairmen.6. After this groundwork is laid, all that remains to be done is the periodic follow-up and checking to see that the job is being done—that's all.

My third and last point brings the public relations of your Auxiliary home to roost where it really belongs. It is just this-Woman's Auxiliary public relations is YOU. The public relations program of your state auxiliary is *yourself* in the final analysis.

To non-medical people, you are a public relations associate of your doctor husband. Do you realize what this can mean to your contacts with groups of people?

As a doctor's wife, each member of your Auxiliary is a representative of the medical profession. How should Mrs. Doctor represent the profession?

Well, for example, an individual woman can do a great deal toward combatting political compulsion in

Your members can themselves be leaders in getting the facts. They can read up on it in the magazines-Hygeia editorials, Time, Newsweek, Better Homes and Gardens, Ladies' Home Journal, Saturday Evening Post, National Physicians Committee publications.

Armed with the facts, Mrs. Doctor can actually be the diplomatic expert on socialized medicine in her own home. Many doctors are too busy healing the sick and studying new medical-scientific trends to study the social and political aspects of their profession. Intelligent women, I think, have a special ability and agility to sense the subtle attacks on the freedom of the profession made by power-seeking bureaucrats. They can arm their own husbands with the facts and encourage him to express himself to others in his community about this alarming problem.

In your own quiet, influential way, you can simply present the facts so that those who know you will at least not be ignorant of the dangers inherent in government medicine, beginning, as it does, with a sweetsounding compulsory health insurance program—apparently for the whole good of all the people!

It is natural for doctors' wives who have so many interests in common to enjoy each others company socially. That's fine. But what good public relations asks is that Auxiliaries do not solely concentrate on social activities. Nothing could create a poorer impression on state and local newspapers and on the community. Each time a county publicity chairman writes a story for the newspapers, she can stress the social service and health and welfare activities of your meet-



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ings rather than the purely social ends. Otherwise the general public begins to think of doctors' families as socialites rather than as thoughtful persons who have a sincere interest in the general welfare of the public.

So public relations is you. And that is the last of my

three basic public relations points today.

First point was-know the issues and relate them to your state program. The second point—choose your specific state targets for the year and around them build your program. The third point—public relations is vou.

And so—it's up to you!

BOOK REVIEWS

A-B-C's of Sulfonamide and Antibiotic Therapy by Perrin H. Long, M.D., F.R.C.P., published by W. B. Saunders Company, Philadelphia and London-1948.

This is a new book "designed for the use of practi-tioners of medicine and surgery." Dr. Long has in-corporated his wide experience in the field and here produces a simple concise statement of practical aspects of the use of proved agents in the treatment of infections processes. Dosage schedules are given for sulfanilamide, sulfadiazine, sulfamerazine, and penicillin. The clinical pharmacology and toxicity of these and streptomycin are discussed. Methods of preparation, drug resistance, and hints on the use of sulfonamides and antibiotics complete the first part comprising fifty-six pages. The remaining one hundred and seventy pages deal with clinical applications under specific diagnostic title. Here Dr. Long presents concise statements of etiology, specific therapy, auxiliary therapy and comment on each disease. The listing is very complete and should cover most situations with which the practitioner will be faced. The author "deseveral frequently used but disproven treatbunks" ment plans. Every practitioner should find this small volume an asset.

W.M.H.

Your Baby, The Complete Baby Book for Mothers and Fathers, by Gladys Denny Shultz and Lee Forrest Hill, M.D., with photography by Joseph Di Pietro and line drawings by Reisie Lonette, published by Doubleday & Company, Inc., Garden City, New York-1948.

This is a very attractive and complete book covering the baby's care from conception to six years. The volume is well illustrated and indexed providing pleasant reading and easy understanding. Contrary to most "baby books" a decided bow is made to the father and one gets the impression at times that this is being overdone. Practical discussions of common infant problems are elearly stated so that they should be well understood and comforting to worried parents. The section on foods is quite clear and should be helpful to the mother. As many "literal" mothers are prone to be hindered rather than aided by any book the physician should be aware of the parents' potentials before advising the use of this contribution. The last thirty-four pages offer a space for recording the growth and development of the infant. This is probably a poor addition as it will tend to turn a reference book for use over a short span into a lasting keepsake and the height of the book does not permit it to be placed on a standard shelf. Furthermore, this section will not fill the bill for twins or families with more than one child—and pediatricians abhor an only child.

W.M.H.

Synopsis of Pediatrics, Fifth Edition, by John Zahorsky, M.D., F.A.C.P., assisted by T. S. Zahorsky, M.D., published by the C. V. Mosby Company, St. Louis, Missouri-1948.

This is the continuation of the pediatrie part of the Synopsis series. An effort is made to include the advances made in the past five years. However, in reading this volume one feels like he is reading an old text of historical interest. The newer therapeutic agents are given only a passing nod. Penicillin is given only a brief mention and streptomycin treated even less well. Antisera no longer available are recommended. The indexing is carelessly done. It is doubtful if the volume will be anything but a hindrance to practitioner or student until a complete re-writing is

W.M.H.

THE ACUTE BACTERIAL DISEASES - Their Diagnosis and Treatment — Harry F. Dowling, M.D. — W. B. Saunders Co. (Philadelphia)

"This book is written with the purpose of combining the new order of diagnosis and treatment with

that which is worthwhile in the old order. It is intended as a practical guide for physicians and interested students." So states the author in his preface. After a perusal of the book, we believe that the author has done what he set out to do.

The first section of the volume deals with general diagnosis of bacterial diseases along with a broad discussion of the various measures used in treatment (sera, sulfonamides, penicillin, streptomycin). Part 2 and 3 take up the diseases caused by the cocci-presenting in clear and readable form the diagnosis of each disease along with general and specific methods of treatment. The last section diseusses the bacterial diseases in which entotoxins are a major factor.

We unhesitatingly endorse this book for a place amongst that small number of volumes which the busy physician keeps on his desk for constant and quick reference.

Dihydrostreptomycin, the new drug which produces significantly less nerve damage than streptomycin, of which it is a derivative, is now available to the medical profession on a nation-wide basis, it was announced today (Thursday) by Carleton H. Palmer, Chairman of the Board of E. R. Squibb & Sons. This announcement followed publication of the official notification in the Federal Register through the U. S. Food and Drug Administration and an announcement by the editor of the American Review of Tuberculosis summarizing the papers of leading clinicians to appear in the November issue of that journal.

According to E. R. Squibb & Sons, all thirteen of the company's branches throughout the U.S. are supplied, and full-scale commercial production is proceeding at the company's manufacturing laboratories in New Brunswick, N. J. Dihydrostreptomycin is available at no increase in price over forms of streptomycin

hitherto available.

NEWS ITEMS

Dr. William Weston and Dr. William Weston, Jr. of Columbia have announced the association of Dr. C. Benton Burns in the practice of pediatrics.

Dr. Harry B. Mustard, Jr. has opened offices in Anderson where he will practice pediatrics.

Dr. John L. Bruce of Florence has announced the association of Dr. W. Leslie Mills in the practice of general medicine and surgery.

Dr. John R. Timmons and Dr. Frances Lovejoy Timmons have announced the opening of offices in Columbia for the practice of general surgery and gynecology.

Dr. J. Warren White of Greenville has been appointed by the United States Army to serve on a commission to survey orthopedic problems in Japan. Congratulations, Warren.

SOUTHEASTERN ALLERGY ASSOCIATION BULLETIN

The fourth annual meeting of the Southeastern

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LAWRENCE A. RAGGIO

P. O. Box 583 Rock Hill, South Carolina Distributor for H. G. FISCHER & CO. Allergy Association will be held at the Washington-Duke Hotel, Durham, N. C., on Saturday and Sunday, January 22 and 23, 1949.

Plans for the program are progressing nicely. Dr. George Rockwell, president of the American College of Allergists, and Dr. Walter Winkenwerder, president of the American Academy of Allergy, are to be the guest speakers. There will be a panel on "Infectious Asthmas" headed by Dr. Oscar Swineford and a panel on "Food Allergies" headed by Dr. Hal Davison.

This year the program committee is asking for two volunteers to present papers at the afternoon session. These papers will have to be limited to 20 minutes, with 10 minute discussions. Anyone desirous of presenting a paper, please get in touch with the secretary

Saturday noon there will be an informal luncheon for members. Saturday night there will be the regular banquet, to be held at the Washington-Duke Hotel. As usual, this will be the time for all the wives to renew their acquaintances, so be certain to bring your wife.

Make your hotel reservations directly with the hotel—and it is suggested that this be done early!

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From where I sit by Joe Marsh

How to Celebrate Your Wedding Anniversary

The "Dutch" Millers celebrated their Tin Wedding Anniversary Saturday. Everything had to be tin. Folks even ate off tin plates, and drank coffee out of tin cups.

When it was time to drink a toast to the "bride and groom," out came the final touch: cold beer in cans. And come the Millers' 15th anniversary (Glass) I expect we'll be toasting them with sparkling beer in bottles!

And I just couldn't help thinking that there was a real lesson for married folks in the way that Dutch and his missus have got along together—in their policy of live-and-let-live, with never a criticism of each other's differences in taste.

From where I sit, it's due to two things: Temperance—as that moderate preference for beer suggests, and Tolerance—for their own differences of opinion—and for the tastes of others, whether applied to beer, to politics, or how to celebrate an anniversary.

Joe Marsh

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